

# Exhibit AAA

**Rosen, Max**

**From:** Rosen, Max  
**Sent:** Wednesday, February 08, 2017 1:02 PM  
**To:** Brennan, Darren; Tennyson, Joseph; Robinson, Kimberly (Pulmonary); Roach, Steve; Brown, Douglas  
**Cc:** Rosen, Max  
**Subject:** Meeting – Review of Radiology issues at Marlborough:  
**Categories:** Desai\_Confidential

Please let me know if anyone has any edits, etc.

Thanks for meeting with me and Darren.  
 Max

Meeting – Review of Radiology issues at Marlborough:

Drs. Rosen, Brennan, Tennyson, Robinson, Mr. Roach & Brown Jan 31, 2017

1. Actions taken to address concerns about turn around time and accessibility of Radiologists:
  - o Changed staffing model: All studies read on site (at Marlborough) expect Neuro, Peds, ED, Nucs
  - o Radiology has created Community Radiology Division to be more responsive to community needs
  - o New Community Neuroradiology rotation: M-F 8 am to 10 pm, one single phone number for point of contact
  - o Extended hours for Community Radiology until 8 pm, M-F
  - o Trainees will not be reading Marlborough studies
  - o Will work with new version of PowerScribe to see if time-stamp for addenda can be designed to not “add” to TAT BRENNAN [ ]
  - o Dr. Brennan will report monthly Radiology TAT to Med-Exec
2. Chest:
  - o Dr. Schmidlin now has home workstation
  - o Drs. Schmidlin and Dill will read all high resolution chest CTs
  - o Will create template to standardize all chest CT reads DILL [ ]
  - o Template for CXR has been implemented, feedback has been positive
  - o Quality issues: Dr. Rosen will perform focused peer-review for physician where issues have been raised. ROSEN [ ]
3. Stroke: Will work on streamlining stroke activation & review current performance BRENNAN [ ]
4. Identification of inpatient exams needing to be read at night/weekends:
  - o Dr. Brennan will work with Paul Riggieri to have techs manually mark all inpatient CTs “stat” when performed nights/weekends. BRENNAN [ ]
5. QA:
  - o Dr. Rosen has reviewed, and provided feedback for Dr. Robinson for neuro case that was questioned.
  - o Radiology will provide access to the person from Marlborough who maintains the QA reporting system (? STARS) so that any Radiology cases can be entered in the Radiology (Pe BRENNAN [ ]
  - o

Max P. Rosen, M.D.

Exhibit\_27

5/7/2021

Max P. Rosen, MD MPH  
Professor and Chair  
U Mass Memorial Medical Center  
U Mass School of Medicine  
55 Lake Ave. North - Room S2-824  
Worcester, MA 01655  
508-856-3252  
508-856-4910 fax

[max.rosen@umassmemorial.org](mailto:max.rosen@umassmemorial.org)  
Follow me on [LinkedIn](#) or [Twitter](#)  
[www.umassmed.edu/radiology](http://www.umassmed.edu/radiology)

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# Exhibit BBB

**From:** Green, Kathryn (Radiology) <Kathy.Green@umassmemorial.org>  
**Sent:** Wednesday, February 1, 2017 11:12 AM  
**To:** Rosen, Max <Max.Rosen@umassmemorial.org>  
**Cc:** Baccei, Steven <Steven.Baccei@umassmemorial.org>  
**Subject:** Re: confidential QA

---

Am aware of confidential nature and already discussed confidentially with Julie. No one else will be involved in this process.

I think life image is best option. We can de-identify and attach the report to the images. I'll work directly with Julie on this.

Sent from my iPhone

On Feb 1, 2017, at 10:34 AM, Rosen, Max <Max.Rosen@umassmemorial.org> wrote:

Hi -

Just want to state that this is a confidential review, which has been requested by a clinician outside of radiology. Please make sure that no one involved discusses this with Charu or with anyone else.

I would like reports and images de-identified.

Can we get

1. 25 Random Chest CTs (and reports) dictated by Dr. Desai
2. 25 Chest CTs (and reports) dictated by other attending
3. The reports can be printed and I can cut out the attending's name.
4. If we can then have the images loaded onto life images, I could then have an outside reviewer review the image once they have access to Life Images.

Let me know if this makes sense.

Thanks. Max

---

**From:** Green, Kathryn (Radiology)  
**Sent:** Wednesday, February 01, 2017 10:21 AM  
**To:** Rosen, Max; Baccei, Steven  
**Subject:**

I'm working with Julie to pull reports and images together for Charu but I need to know:

1. Is this an external or internal review? It will help to know in terms of whether we need to de-identify patient information or just the physician info.
2. Also, it might be a little complicated to attach the report to images. However, I thought we might be able to do this through LifelImage. If we can do this through LifelImage it will save an enormous amount of time for the File room.

Please let me know  
Thanks

Max P. Rosen, M.D.  
Exhibit\_26  
5/7/2021

**CONFIDENTIAL**

**UMM-04745**

K

*Sr. Director, Radiology Services*

*UMass Memorial Medical Center*

*55 Lake Ave, North*

*Worcester, MA 01655*

*(774) 443-2631 office*

*(508) 426-0706 pager*

<< OLE Object: Picture (Device Independent Bitmap) >>

# Exhibit CCC

# Methods

- 50 random Chest CTs
  - 25 CD
  - 25 Control (several radiologists)
- Blinded review, experienced chest Radiologist not at UMMMC
  - Discrepancy Y/N
    - Detail of discrepancy
  - Major / Minor
  - Impact on patient care Y/N

# Exhibit DDD

UNITED STATES DISTRICT COURT  
DISTRICT OF MASSACHUSETTS

CIVIL ACTION NO. 4:19-cv-10520-DHH

CHARU DESAI,  
Plaintiff,

v.

UMASS MEMORIAL MEDICAL  
CENTER, INC., et al.,  
Defendants.

**DEFENDANT, MAX ROSEN, M.D.'S  
ANSWERS TO PLAINTIFF'S  
SECOND SET OF  
INTERROGATORIES**

Pursuant to the provisions of Rule 33 of the Federal Rules of Civil Procedure, Defendant Max Rosen, M.D., hereby answers the Plaintiff's Second Set of Interrogatories as follows:

GENERAL OBJECTIONS

1. Defendant objects to the Interrogatories to the extent they seek information protected by the attorney-client privilege, attorney work product doctrine, and/or information that is not otherwise subject to discovery pursuant to the Federal Rules of Civil Procedure.
2. Defendant objects to the Interrogatories to the extent that they seek to impose obligations upon Defendant that exceed those imposed by the Federal Rules of Civil Procedure.
3. Defendant objects to the Interrogatories to the extent that they seek information not relevant to the subject matter of this litigation and/or are not reasonably calculated to lead to the discovery of admissible evidence.
4. Defendant objects to the Interrogatories to the extent that they contain vague, ambiguous, conclusory, and/or undefined terms.

5. Defendant objects to the Interrogatories to the extent that they are overbroad, unreasonable in scope, unduly burdensome, oppressive and/or require unreasonable expense to answer.

6. Defendant objects to the Interrogatories to the extent they seek confidential information subject to statutory rights of privacy.

7. Defendant objects to the temporal scope of the Interrogatories as being grossly overbroad, unreasonable, and unduly burdensome.

RESPONSES

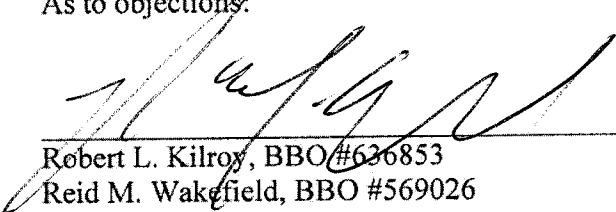
**INTERROGATORY NO. 1.** Please identify by name and department each physician, other than Dr. Desai, whose radiology readings were included in Dr. Diana Litmanovich's review of Dr. Desai, located at UMM 00695-696. Your response should indicate which physician read each study (QACH 1-50).

**ANSWER NO. 1.** Please see the attached Exhibit A.

Signed under the pains and penalties of perjury this 16 day of June, 2021.

  
Max Rosen, M.D.


As to objections:

  
Robert L. Kilroy, BBO #626853  
Reid M. Wakefield, BBO #569026  
Mirick, O'Connell, DeMallie & Lougee, LLP  
1800 West Park Drive, Suite 400  
Westborough, MA 01581-3926  
Phone 508.860.1474  
Fax 508.983.6261  
[rkilroy@mirickoconnell.com](mailto:rkilroy@mirickoconnell.com)  
[rwakefield@mirickoconnell.com](mailto:rwakefield@mirickoconnell.com)

Dated: June 16, 2021

CERTIFICATE OF SERVICE

I, Reid M. Wakefield, hereby certify that I have this day served a copy of the foregoing document, by email to Patricia A. Washienko, Esq., and Brendan T. Sweeney, Esq., Frieberger & Washienko LLC, at pwashienko@fwlawboston.com and bsweeney@fwlawboston.com, and Mark Johnson, Esq., University of Massachusetts Office of the General Counsel, at MAJohnson@umassp.edu.

  
Reid M. Wakefield

Dated: June 24, 2021

**Exhibit A**

<b>Number</b>	<b>Name</b>	<b>Division/Specialty</b>
QACH01	Hao Lo, M.D.	Emergency
QACH02	Hao Lo, M.D.	Emergency
QACH03	Hao Lo, M.D.	Emergency
QACH04	Dennis Coughlin, M.D.	Emergency
QACH12	Dennis Coughlin, M.D.	Emergency
QACH13	Karin Dill, M.D.	Thoracic
QACH14	Karin Dill, M.D.	Thoracic
QACH15	Karin Dill, M.D.	Thoracic
QACH16	Hao Lo, M.D.	Emergency
QACH17	Hao Lo, M.D.	Emergency
QACH18	Hao Lo, M.D.	Emergency
QACH19	Hadeer Shaikhly, M.D.	Musculoskeletal
QACH20	Hadeer Shaikhly, M.D.	Musculoskeletal
QACH21	Hadeer Shaikhly, M.D.	Musculoskeletal
QACH22	Darren Brennan, M.D.	Abdomen/Community
QACH23	Darren Brennan, M.D.	Abdomen/Community
QACH24	Darren Brennan, M.D.	Abdomen/Community
QACH25	Darren Brennan, M.D.	Abdomen/Community
QACH26	Dennis Coughlin, M.D.	Emergency
QACH27	Carolyn Dupuis, M.D.	Emergency
QACH28	Carolyn Dupuis, M.D.	Emergency
QACH45	Karin Dill, M.D.	Thoracic
QACH46	Karin Dill, M.D.	Thoracic
QACH47	Karin Dill, M.D.	Thoracic
QACH48	Karin Dill, M.D.	Thoracic

**CONFIDENTIAL**

# Exhibit EEE

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**From:** Rosen, Max  
**Sent:** Saturday, August 26, 2017 1:42 PM  
**To:** 'Litmanovich,Diana (HMFP - Radiology)'  
**Cc:** Rosen, Max  
**Subject:** RE: QA project  
I made an Excel sheet along the same lines. Are you ok using this? Max

---

**From:** Litmanovich,Diana (HMFP - Radiology) [<mailto:dlitmano@bidmc.harvard.edu>]  
**Sent:** Tuesday, August 22, 2017 4:42 AM  
**To:** Rosen, Max <[Max.Rosen@umassmemorial.org](mailto:Max.Rosen@umassmemorial.org)>  
**Subject:** QA project

Hi Max,

In a continuation of our discussion, I am sending you the parameters I have used for a relatively similar project.

Let me know if htis would be ok or you would like me to modify.

Thank you

Diana

---

This message is intended for the use of the person(s) to whom it may be addressed. It may contain information that is privileged, confidential, or otherwise protected from disclosure under applicable law. If you are not the intended recipient, any dissemination, distribution, copying, or use of this information is prohibited. If you have received this message in error, please permanently delete it and immediately notify the sender. Thank you.

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# Exhibit FFF

**Rosen, Max**

---

**From:** Brennan, Darren  
**Sent:** Thursday, September 21, 2017 1:48 PM  
**To:** Rosen, Max  
**Subject:** Fwd: Incident today on 9/21/2017

---

**From:** "Desai, Charu" <Charu.Desai@umassmemorial.org>  
**Subject:** Incident today on 9/21/2017  
**Date:** 21 September 2017 13:46  
**To:** "Brennan, Darren" <Darren.Brennan@umassmemorial.org>  
**Cc:** "Desai, Charu" <Charu.Desai@umassmemorial.org>

Hi Darren,

Regarding an incident this morning on Thursday, 9/21/2017 at 10AM; I asked Karin to speak with me in my office today. She did come to my office and we spoke. The conversation lasted approximately two minutes. I told her that I did not appreciate that she was rude a couple of days ago; Dr. Dill said "I want to sign out the resident".

Dr. Dill stated that I have been rude to her as well. I was stating with my index finger that it was only once. I definitely was not rude but Dr. Dill believed that I was (this was at a monthly chest division meeting and Dr. Sena was there as well). Dr. Dill became angry and walked out of my office.

Thank you for your time and have a good day.

Charu

# Exhibit GGG

**From:** Brennan, Darren <Darren.Brennan@umassmemorial.org>  
**Sent:** Thursday, September 21, 2017 10:27 AM  
**To:** Desai, Charu <Charu.Desai@umassmemorial.org>  
**Cc:** Rosen, Max <Max.Rosen@umassmemorial.org>  
**Subject:** Incident with Dr Dill today

---

Charu

Max is out today so this has come to me today . I have asked Karin for and already received a short written statement of her version of today's incident in your office so now can I ask the same of you? - just what led up to and what your remember for the conversation

Also , my cell is [REDACTED] : please feel free to call me if you want

DB

**UMM-03867**

# Exhibit HHH

**Subject: Fwd:**

---

**From:** "Desai, Charu" <[Charu.Desai@umassmemorial.org](mailto:Charu.Desai@umassmemorial.org)>

**Subject:**

**Date:** 21 September 2017 14:12

**To:** "Brennan, Darren" <[Darren.Brennan@umassmemorial.org](mailto:Darren.Brennan@umassmemorial.org)>

Hi, Darren,

I am sorry to have to bring the following issue to your attention. Dr. Karin Dill, MD has had several inappropriate interactions with me since she began working in the Chest Division. I will highlight the most recent one below.

This past week, she rudely interfered , in front of the resident, inappropriately stated that she would like to sign-out with the resident. Because she is rarely even visible in the department, the burden of signing out the residents' cases is most entirely on me. This is unfair and unacceptable. When I professionally confronted her about this issue by taking her aside (we met in my office and I politely indicated to her that I would appreciate if she avoids future rude interactions with me, especially in the presence of a resident), she yet again became inappropriately aggressive and stormed out of the room. Her behavior is unacceptable.

I also would like to mention that her lack of presence in the Division (claiming that she is working from home, never tending to her several responsibilities to the service and signing out with the resident, calling in sick for extended periods) is unfair to me, the chest division, and to patient care. Due to her lack of presence on most days, I am forced to unfairly take on the burden of the entire division, including signing out with the resident. Her lack of commitment to the service or the work is extremely unfair and unacceptable for patient care.

I have a witness to confirm the lack of professionalism associated with her interaction with me last week. I will not tolerate her inappropriate behavior any longer. I will not hesitate to escalate the issue shall the need arise.

Thanks so much for your time.

Sincerely,  
Charu

**UMM-04549**

# Exhibit III

**From:** Rosen, Max <max.rosen@exchange.com>  
**Sent:** Friday, September 22, 2017 7:29 AM  
**To:** Emrich, Kelly <Kelly.Emrich@umassmemorial.org>  
**Subject:** Re: Confidential

---

Do you have the time stamps

Sent from my iPhone

On Sep 22, 2017, at 7:18 AM, Emrich, Kelly <[Kelly.Emrich@umassmemorial.org](mailto:Kelly.Emrich@umassmemorial.org)> wrote:

Of course:

7 CTs

33 CR

Count of Accession	
Exam	Total
CTC0 - CT: Chest without Contrast	1
CTC1 - CT: Chest with Contrast	6
DXCH1 - Chest:PA,AP, Apical or Lateral	10
DXCH2 - Chest, PA and Lateral	22
DXCH2 - DX: Chest: PA and Lat (2 Vws)	1
Grand Total	40

-----Original Message-----

From: Rosen, Max  
Sent: Thursday, September 21, 2017 6:39 PM  
To: Emrich, Kelly <[Kelly.Emrich@umassmemorial.org](mailto:Kelly.Emrich@umassmemorial.org)>  
Subject: Confidential

Hi KELLY,

Can you please run a report for everything that Dr. Desai read on Thursday, September 21. Thanks so much.

Max

Sent from my iPhone

# Exhibit JJJ

---

**From:** Rosen, Max  
**Sent:** Friday, October 13, 2017 1:34 PM  
**To:** Mowloud, Randa ; Litmanovich,Diana (HMFP - Radiology)  
**Cc:** Wilson, Cindy ; Beaudoin, Stephen  
**Subject:** RE: consultant for QA project  
Thanks – Diana let me know if you need help.  
Deidentified reports are under the “attachment” tab.  
Max

---

**From:** Mowloud, Randa  
**Sent:** Friday, October 13, 2017 1:27 PM  
**To:** Litmanovich,Diana (HMFP - Radiology) <[dlitmano@bidmc.harvard.edu](mailto:dlitmano@bidmc.harvard.edu)>  
**Cc:** Wilson, Cindy <[Cindy.Wilson@umassmemorial.org](mailto:Cindy.Wilson@umassmemorial.org)>; Rosen, Max  
<[Max.Rosen@umassmemorial.org](mailto:Max.Rosen@umassmemorial.org)>; Beaudoin, Stephen <[Steven.Beaudoin@umassmemorial.org](mailto:Steven.Beaudoin@umassmemorial.org)>  
**Subject:** RE: consultant for QA project  
Hi Dr. Litmanovich,  
You have been given access to the UMASS network. Attached are the Remote Access instructions.  
User name: LitmanoD.  
Temporary password: You can try the following temporary password: First initial last initial (upper)  
xx (lower) last 4 of Cell (*example RMxx0000*). If it does not work, please call the help desk (508-  
334-8800).

Once you log-in:

- Go to the internet (explorer or other browser)
- You will be directed to our intranet (called OurNet)
- Select “Resources” listed on the green horizontal bar
- Select “**New! Life Image**” (from alphabetical list on right side of screen- listed under “L”)
- Click on the <https://lifeimage.umassmemorial.org> link
- Change Domain to UMASS Memorial
- Select “MD” profession
- Click on Continue

Steve Beaudoin will receive an e-mail letting him know you logged in and he will grant you access to the QA Radiology Library.

Let me know if you have questions.

Thank you.

Randa

Randa Mowloud

Group Practice Administrator

Department of Radiology

University Campus- Room S2-824

55 Lake Ave North, Worcester, MA 01655

508 334-7755 Fax 508 856-4910

Email [Randa.Mowloud@umassmemorial.org](mailto:Randa.Mowloud@umassmemorial.org)

---

**From:** Rosen, Max  
**Sent:** Monday, September 18, 2017 9:16 PM  
**To:** Litmanovich,Diana (HMFP - Radiology) <[dlitmano@bidmc.harvard.edu](mailto:dlitmano@bidmc.harvard.edu)>

**Cc:** Mowloud, Randa <[Randa.Mowloud@umassmemorial.org](mailto:Randa.Mowloud@umassmemorial.org)>; Wilson, Cindy  
<[Cindy.Wilson@umassmemorial.org](mailto:Cindy.Wilson@umassmemorial.org)>

**Subject:** FW: consultant for QA project

Hi Diana,

Attached is the draft of the contract. If ok, please let me and Cindy know, also let me know your preferred mailing address. I'll then get you signed copy, and we can start.

Thanks Max

**Max P. Rosen MD MPH**  
**Professor and Chairman**  
**Department of Radiology**  
**UMass Memorial Medical Center**  
**55 Lake Avenue North - Room S2-824**  
**Worcester, MA 01655**  
**Phone: 508/856-3252**  
**Fax: 508/856-4910**  
[max.rosen@umassmemorial.org](mailto:max.rosen@umassmemorial.org)

---

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# Exhibit KKK

---

**From:** Rosen, Max  
**Sent:** Thursday, December 07, 2017 8:42 PM  
**To:** Litmanovich,Diana (HMFP - Radiology) ; Beaudoin, Stephen  
**Cc:** Mowloud, Randa ; Wilson, Cindy  
**Subject:** RE: consultant for QA project  
Thanks. Glad you're able to read them. Max

**Max P. Rosen MD MPH**  
**Professor and Chairman**  
**Department of Radiology**  
**UMass Memorial Medical Center**  
**55 Lake Avenue North - Room S2-824**  
**Worcester, MA 01655**  
**Phone: 508/856-3252**  
**Fax: 508/856-4910**  
[max.rosen@umassmemorial.org](mailto:max.rosen@umassmemorial.org)

---

**From:** Litmanovich,Diana (HMFP - Radiology) [dlitmano@bidmc.harvard.edu]  
**Sent:** Wednesday, December 06, 2017 9:03 AM  
**To:** Beaudoin, Stephen; Rosen, Max  
**Cc:** Mowloud, Randa; Wilson, Cindy  
**Subject:** RE: consultant for QA project

Hi,  
I was able to log in and work on cases. They are loading relatively slow, but otherwise it works fine.  
Thank you.

Diana

*Diana Litmanovich, MD*  
*Associate Professor of Radiology, Harvard Medical School, FNASCI*  
*Director of Cardiac CT,*  
*Director of the Longitudinal Radiology in Medicine PCE course,*  
*Director of Cardiothoracic Fellowship*  
*Radiology, Beth Israel Deaconess Medical Center*  
*330 Brookline Ave, Boston, MA 02215*  
[dlitmano@bidmc.harvard.edu](mailto:dlitmano@bidmc.harvard.edu)

---

**From:** Beaudoin, Stephen [<mailto:Steven.Beaudoin@umassmemorial.org>]  
**Sent:** Sunday, December 03, 2017 5:44 PM  
**To:** Rosen, Max; Litmanovich,Diana (HMFP - Radiology)  
**Cc:** Mowloud, Randa; Wilson, Cindy  
**Subject:** [External] RE: consultant for QA project  
<https://lifeimage.umassmemorial.org/inbox/login.jsp>

I added Dr Litmanovich to the QA Group.

If you log into the lifeImage website you will see the QA group. There are 50 cases on file with the

**UMM 00548**

reports attached to the files.

If you're having any trouble you can contact me. I will be off on Monday returning on Tuesday.

*Stephen Beaudoin*

*Director of Radiology Operations*

*UMass Memorial Medical Center*

*University campus*

*55 Lake Ave, North*

*Worcester, MA 01655*

*(774) 442-1929 office*

*(508) 426-1050 pager*

---

**From:** Rosen, Max

**Sent:** Sunday, December 03, 2017 9:22 AM

**To:** Litmanovich, Diana (HMFP - Radiology) <[dlitmano@bidmc.harvard.edu](mailto:dlitmano@bidmc.harvard.edu)>

**Cc:** Mowlood, Randa <[Randa.Mowlood@umassmemorial.org](mailto:Randa.Mowlood@umassmemorial.org)>; Wilson, Cindy  
<[Cindy.Wilson@umassmemorial.org](mailto:Cindy.Wilson@umassmemorial.org)>; Beaudoin, Stephen <[Steven.Beaudoin@umassmemorial.org](mailto:Steven.Beaudoin@umassmemorial.org)>

**Subject:** Re: consultant for QA project

Hi. Not sure what you need. Can you call me. Thanks. Max

Sent from my iPhone

On Dec 2, 2017, at 5:37 PM, Litmanovich, Diana (HMFP - Radiology) <[dlitmano@bidmc.harvard.edu](mailto:dlitmano@bidmc.harvard.edu)> wrote:

Dear Randa and Stephen,

I have followed instructions and logged in.

Please let me know what would be the next step

My password (if needed) is Shai1999.

Username LitmanoD

Thank you

Diana

*Diana Litmanovich, MD*

*Associate Professor of Radiology,*

*Harvard Medical School, FNASCI*

*Director of Cardiac CT,*

*Director of the Longitudinal radiology in Medicine PCE course,*

*Director of Cardiothoracic Fellowship*

*Radiologist, Department of Diagnostic Radiology*

*Beth Israel Deaconess Medical Center*

*330 Brookline Ave, Boston, MA 02215*

*[dlitmano@bidmc.harvard.edu](mailto:dlitmano@bidmc.harvard.edu)*

---

**From:** Mowlood, Randa <[Randa.Mowlood@umassmemorial.org](mailto:Randa.Mowlood@umassmemorial.org)>

**Sent:** Friday, October 13, 2017 1:26 PM

**To:** Litmanovich,Diana (HMFP - Radiology)

**Cc:** Wilson, Cindy; Rosen, Max; Beaudoin, Stephen

**Subject:** [External] RE: consultant for QA project

Hi Dr. Litmanovich,

You have been given access to the UMASS network. Attached are the Remote Access instructions.

User name: LitmanoD.

Temporary password: You can try the following temporary password: First initial last initial (upper) xx (lower) last 4 of Cell (*example RMxx0000*). If it does not work, please call the help desk (508-334-8800).

Once you log-in:

- Go to the internet (explorer or other browser)
- You will be directed to our intranet (called OurNet)
- Select "Resources" listed on the green horizontal bar
- Select "**New! Life Image**" (from alphabetical list on right side of screen- listed under "L")
- Click on the <https://lifeimage.umassmemorial.org> link
- Change Domain to UMASS Memorial
- Select "MD" profession
- Click on Continue

Steve Beaudoin will receive an e-mail letting him know you logged in and he will grant you access to the QA Radiology Library.

Let me know if you have questions.

Thank you.

Randa

Randa Mowlod

Group Practice Administrator

Department of Radiology

University Campus- Room S2-824

55 Lake Ave North, Worcester, MA 01655

508 334-7755 Fax 508 856-4910

Email [Randa.Mowlod@umassmemorial.org](mailto:Randa.Mowlod@umassmemorial.org)

---

**From:** Rosen, Max

**Sent:** Monday, September 18, 2017 9:16 PM

**To:** Litmanovich,Diana (HMFP - Radiology) <[dlitmano@bidmc.harvard.edu](mailto:dlitmano@bidmc.harvard.edu)>

**Cc:** Mowlod, Randa <[Randa.Mowlod@umassmemorial.org](mailto:Randa.Mowlod@umassmemorial.org)>; Wilson, Cindy <[Cindy.Wilson@umassmemorial.org](mailto:Cindy.Wilson@umassmemorial.org)>

**Subject:** FW: consultant for QA project

Hi Diana,

Attached is the draft of the contract. If ok, please let me and Cindy know, also let me know your preferred mailing address. I'll then get you signed copy, and we can start.

Thanks Max

**Max P. Rosen MD MPH**

**Professor and Chairman**

**Department of Radiology**

**UMM 00550**

**UMass Memorial Medical Center**  
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**Phone: 508/856-3252**  
**Fax: 508/856-4910**  
[max.rosen@umassmemorial.org](mailto:max.rosen@umassmemorial.org)

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# Exhibit LLL

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**From:** Rosen, Max  
**Sent:** Tuesday, December 26, 2017 12:28 PM  
**To:** Mowloud, Randa  
**Subject:** FW: Project

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**From:** Litmanovich, Diana (HMFP - Radiology) [<mailto:dlitmano@bidmc.harvard.edu>]  
**Sent:** Monday, December 25, 2017 11:58 PM  
**To:** Rosen, Max <[Max.Rosen@umassmemorial.org](mailto:Max.Rosen@umassmemorial.org)>  
**Subject:** Project

Dear Dr. Rosen,

Dear Max,

Please see attached the summary fo the project.

Thank you for extending me the opportunity to contribute to the QA efforts.

Happy new Year and best wishes!

Diana

*Diana Litmanovich, MD  
Associate Professor of Radiology, Harvard Medical School, FNASCI  
Director of Cardiac CT,  
Director of the longitudinal radiology PCE course,  
Director of Cardiothoracic Fellowship  
Radiology, Beth Israel Deaconess Medical Center  
330 Brookline Ave, Boston, MA 02215  
[dlitmano@bidmc.harvard.edu](mailto:dlitmano@bidmc.harvard.edu)*

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# Exhibit MMM

Pateint #	Acc Number	Type (I-, I+, CTA, etc)	Agree with interpretation Y/N)	If no: Major or Minor disagreement	Impact on patient care (Y/N)	Discrepancy 1	Discrepancy 2	Discrpancy 3	Comments
1	QACH01	I-	No	Minor	Yes	Findings that were not mentioned:Pulmonary hypertention, non-hemorrhagic nature of pleural effusion, although still most likely traumatic			
2	QACH02	I-	No	Minor	No	Listed 5 to 9 rib fractures, I see 5-6 rib fractures			
3	QACH03	I-	Yes						Patient has atrophic kidney, most likely CKD, not mentioned
4	QACH04	CTA	yes						
5	QACH05	CTA	yes						
6	QACH06	CTA	Yes						
7	QACH07	CTA	Yes						
8	QACH08	CTA	No	Major	Yes	No distinction made in the report between pneumonia and rounded atelectasis, all named consolidations, where , in fact, right lower lobe and lingular rounded atelectasis are less important than large pneumonia in left lower lobe in the post-operative lung			
9	QACH09	CTA	NO	Major	Yes	No pulmonary edema seen, the findigs are of multifocal infection or less likely fat emboli, to be considerd under those clinical circumstances			
10	QACH10	CPA	No	Major	Yes	Multifocal pneumonia and bronchitis not clearly stated			
11	QACH11	I+	No	Minor	Yes	Multifocal opacities are not contusions, but infection or aspiration			
12	QACH12	I+	Yes						
13	QACH13	I+	Yes						
14	QACH14	I+	No	Minor					
15	QACH15	I+	No	Minor	Yes	Small and large arway inflammation/infection			
16	QACH16	I+	No	Minor	Yes	Large airway inflammation/infection, severe Mediastinal and hilar mild lymphadenopathy wasn't mentioned			
17	QACH17	I+	Yes						
18	QACH18	I-	Yes						
19	QACH 19	I-	Yes						
20	QACH20	I-	Yes						
21	QACH21	i-	Yes			Typos in the final impression			

22	QACH22	I-	No	major	Yes	Severe bronchiectasis and airtrapping,	Findings concerning for MAI, not even mentioned
23	QACH23	I-	Yes				
24	QACH24	I-	No	Minor	Yes	Emphysema, not cystic lung disease	
25	QACH25	I-	Yes				
26	QACH26	CTA	Yes				
27	QACH27	CTA	Yes				
28	QACH28	CTA	Yes				
29	QACH29	I+	Yes				
30	QACH30	I-	No	Major	Yes	Extensive secretions in trachea,	Most likely aspiration in left lung base AND potentially pneumonia in left apex . No mentioning if new or old or no comparison available Mediastinal Lymph nodes are most likely reactive
31	QACH31	I-	Yes				
32	QACH32	I-	Yes			Recommendations for the follow-up of pulmonary nodules are not in concordance with Fleischner guidelines Lower right chest tube is not in the pleural space, this is not clearly stated	
33	QACH33	I-	No	Major	Yes		
34	QACH34	I-	No	Minor	yes	Severe bornchitis with left loer lobe pneumonia	
35	QACH35	I-	Yes				
36	QACH36	I-	Yes				
37	QACH37	I-	Yes				
38	QACH38	I-	No	Minor	Yes	Severe large and small airway disease with severe airtrapping in lower lobers right more than left	
39	QACH39	I+	Yes				
40	QA40CH	I+	Yes				
41	QA41CH	I+	Yes				
42	QACH42	I+	No	Minor	Yes	Second Primary cancer (lung) is much more likely then metastatic disease Very extensive network of venous collaterals has not been mentioned.	
43	QACH43	I+	Yes				
44	QACH44	I+	Yes				
45	QACH45	I+	Yes				
46	QACH46	CTA	Yes				
47	QACH47	CTA	Yes				
48	QACH48	CTA	No	Minor	Chronic bronchtis should be called	Right hilar LN should be suggested to be followed in 3 months	

49 QACH49	C+	Yes				
50 QACH50	C-	No	Minor	No?	LLL endobronchial secretion called pulmonary nodule	Postradiation changes were called pleural thickening

Dear Dr. Rosen,

I have personally reviewed 50 chest CTs that were selected for review.

The studies have included:

CTPA for pulmonary embolism assessment

CT with IV contrast for assessment of metastatic disease and primary lung malignancy

CT without contrast for assessment of interstitial lung disease

CT with IV contrast to assess in trauma

My general impressions from reviewing the studies are as following:

Positive:

1. The technical quality of the studies is overall very good.
2. No life-threatening misses or misinterpretations were found.

Negative:

1. While differential diagnosis is stated, no recommendations on how to proceed with next step were given.
2. No specific/sufficient attention to airway pathology was demonstrated in the majority of cases.
3. No meaningful differential diagnosis was provided on interstitial lung disease.
4. No appropriate differentiation between cystic lung disease and emphysema was provided in several cases.
5. No assessment of severity of emphysema was provided.
6. Misinterpretation of pulmonary infection, pulmonary edema and aspiration in a few cases was noticed.
7. Misinterpretation of atelectasis vs. pneumonia in 2 cases.
8. Specific comments per each case are in the excel spread sheet.

The overall time that I have spent on reviewing the cases: approximately 16 hours

Please let me know if there are any specific questions, I will be happy to address them.

Kindest Regards,

Diana Litmanovich, MD

# Exhibit NNN

**Expert Report of James F. Gruden, M.D.**

To: Patricia A. Washienko, Esq.  
From: James F. Gruden, M.D.  
Re: Charu Desai v. UMass Memorial Medical Center, et al.  
Date: July 30, 2021

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I. Materials Reviewed

I have reviewed the 50 CT examinations and their official reports (QACH 1- 50; UMM00553-UMM00689) that were interpreted by Dr. Desai and by other radiologists in the same Department at Marlborough Hospital. After reviewing each individual CT examination blindly, I then reviewed the official report for each study and the over-reviewer's provided "log of misreads" one case at a time (UMM00695-UMM00696). I intend to offer opinions on whether Dr. Desai made significant errors; whether the other radiologists made significant errors at Marlborough Hospital; and whether the peer review process here was fair. My opinions are based on my review of the records and radiologic studies, my education and training, my knowledge of the relevant medical literature, and my experience and expertise in the field of radiology, particularly in thoracic radiology.

II. Qualifications, List of Cases, and Fee Schedule

I am a board certified radiologist. I earned a Bachelor of Arts in Economics and Pre-Professional Studies with Highest Honors in 1983 from the University of Notre Dame and my M.D. degree in 1987 from the University of Miami, School of Medicine, where I was class Valedictorian and was inducted to the Alpha Omega Alpha medical honor society. I completed my internship year in Internal Medicine at Cabrini Medical Center in New York, New York. I completed my residency training in Diagnostic Radiology (1988-1992) at the New York Hospital-Cornell Medical Center. I further completed a one-year Fellowship in Thoracic Imaging at the University of California-San Francisco.

I was thereafter appointed as Assistant Professor of Radiology in Residence at the University of California-San Francisco. From 1995 through 2000, I served as Assistant Professor of Radiology at NYU School of Medicine. In early 2000, I was appointed Associate Professor of Radiology and Internal Medicine at Emory University School of Medicine in Atlanta, Georgia. I served as the Division Director of Cardiothoracic Imaging at Emory University Hospital and Clinic and founded Emory's Biomedical Imaging and CT Post-Processing Lab. From 2005 through 2015, I was at the Mayo Clinic Arizona in Phoenix-Scottsdale, Arizona, where I served as the Director of Cardiothoracic Imaging. In January 2015, I was appointed as the Chief of the Division of Body Imaging in the Department of Radiology at Weill Cornell Medical College and at the New York-Presbyterian Hospital-Weill Cornell Campus. I further serve as a Full Professor of Radiology at Weill Cornell Medical College and Assistant Attending Radiologist at the New York-Presbyterian Hospital - Weill Cornell Campus. Through my education, training, review of the medical literature and my other professional activities, I am familiar with the standard of care as it pertains to the practice of radiology, and specifically thoracic radiology.

A copy of my CV including my last 10 years of publications is attached to this report at **Exhibit A**. A list of the cases I have testified in as a witness for the last 4 years is attached at **Exhibit B**. I further state that I am being compensated as an expert in this case at the rate of \$500 per hour. I have spent approximately 28 hours up to this point on this case at the present time.

### III. Summary of Findings and Testimony

Based on my review of the scans and reports, Dr. Desai made no significant errors of interpretation and no errors in reporting and certainly there are, therefore, no errors that would affect immediate patient management or outcome. The reports are concise and accurate without significant typographical or descriptive errors. In addition, the reports do not recommend additional unnecessary imaging examinations. They are well within the expected standard of care at an urban teaching hospital. The “criticisms” of Dr. Desai’s reporting are entirely subjective, and I found none of them to be clinically significant. I elaborate further below.

Of note, all cases were submitted in a small window in early 2017, and I am not certain why this type of “targeted review” was performed. The method of peer review used here does not conform to any appropriate or well-known guidelines for a fair peer review process. This appears to be a hastily performed focused and targeted project, the need for which I do not know. I find no issues with the accuracy or content of Dr. Desai’s reports.

Specific analysis of cases interpreted by Dr. Desai, which the over-reviewer claimed were misreads, are as follows:

#### **QACH08 R/O PE 2/4/17**

The report here states that RLL and RML consolidation are unchanged since recent prior (prior CT was recent)- she did not call this rounded atelectasis, and I assume it was called round atelectasis on the prior exam (I do not have the report from that study). Regardless, the report clearly states that the appearance of the right lung has not changed.

The report mentions worsening consolidation in the LLL in the findings, but this should have been added to the impression. This is a reasonable critique, but the finding was not missed.

OVERALL: This was a PE study on an inpatient with a recent prior. The case was correctly read as no PE, no change RLL and RML consolidation, and worsening LLL consolidation. ***The impression could have added the LLL consolidation, but this is not a major interpretive error. The important findings were made and reported.***

#### **QACH09 R/O PE 2/21/17**

The report correctly states that there is no PE. It mentions a scapular fracture that I do not clearly see but there may have been added clinical information that I do not have. Pneumonia and pulmonary edema can be difficult to distinguish, especially in patients with emphysema (as in this case). The criticism is that the findings suggest pneumonia, not pulmonary edema, and that fat embolism should have been raised as a possibility. Fat embolism occurs in the setting of

long bone fracture, and I do not see that history provided (and I am not sure that your client had this history). Interestingly, the CT appearance of fat embolism looks very much like pulmonary edema so the criticism here is that fat emboli (which would look like “edema”) should have been mentioned but that pulmonary edema should not have been mentioned and the findings were more likely pneumonia. This is not a logical criticism and a patient with long bone fractures and “pulmonary edema” on a CT would be suspected clinically of having fat embolism. We do not directly see “fat embolism” on CT: we see its effects, which look like pulmonary edema.

**OVERALL:** *The reading on this case is well within expected standard of care.* Fat embolism, cardiogenic edema, and diffuse pneumonia can be hard to distinguish with certainty on one CT exam. This is not an uncommon problem, and I am not sure how we decide who is correct in a case such as this, but the initial report looks fine.

**QACH10 R/O PE, 2/27/17**

The critique here states that multifocal pneumonia and bronchitis were not clearly stated, a “major error.” The report very clearly discusses a mild multifocal pneumonia in both the Findings and Impression sections. There is also an issue because the report did not mention “bronchitis.” However, emphysema was mentioned in this report. Emphysema indicates a history of significant cigarette smoking which is basically always associated with “bronchitis.” The “bronchitis” in these patients is typically chronic and managed clinically. The scan quality is poor (breathing artifact, mentioned in report) and the exam is therefore more difficult to interpret, but again, it was correctly read as to the primary indication: no PE. We rarely mention “bronchitis” in patients with emphysema as it can be assumed to be present.

**OVERALL:** *I do not see the point of the criticism. The report is accurate.*

**QACH11 R/O PE, 3/7/17**

I am not sure what the critique here is. It refers to contusions being reported, but that was reported in Case 12, not Case 11, and in that case, I agree that they are likely not contusions. Case 12 was not read by your client according to my records. However, in Case 11, if that is really the case in question, I see no problem with the interpretation or report. Again, the scan quality is not great (breathing artifact).

**OVERALL:** *No discrepancy or problem with Case 11. The critique appears to apply to Case 12, which I am happy to address if needed.*

**QACH30 noncontrast CT for Dyspnea, 2/25/17**

A prior CT was two weeks earlier (although I do not have access to the report). The current report describes “infiltrates” in the left lung in both the Findings and Impression sections. While they are not specifically reported as NEW (as the critique states), the scan two weeks ago likely did not report this finding, and the referring physicians are able to realize that the findings are new based on the report, the clinical change in the patient, and referring to the prior scans and the prior report. Secretions in the trachea (not mentioned and raised as a criticism) are present in many patients with pneumonia (and COPD) and failure to mention this finding is not at all important in this instance. It is really a subjective decision by the radiologist as to whether this finding is significant enough to place in the report (it was not in this case). The lymph nodes may well be reactive (as stated in the criticism), but in a patient with a history of an advanced cancer, I see no problem with following these with a future CT to be sure. That is actually the standard of care in this instance.

**OVERALL:** *Quarrels with the use of the word “new”, the failure to mention tracheal secretions, and the critique of the recommended follow-up of mediastinal adenopathy are unfounded and based on subjective opinion. There is nothing wrong with this report.*

#### **QACH33 noncontrast CT for air leak, 2/16/17**

This is a complex patient with many findings and no prior imaging. The report accurately reports all the important findings. The criticism centers on the position of one of the chest tubes, which is in fact reported as IN THE MEDIASTINUM in both the Findings and Impression of the report, and there is documentation of a call to the clinical team discussing the results.

**OVERALL:** *The chest tube in question is reported as IN THE MEDIASTINUM. It is clear this means it is NOT in the pleural space. The criticism is unfounded.*

#### **QACH34 noncontrast CT for cough and weight loss, 2/14/17**

The report very clearly describes both emphysema and COPD and describes secretions in the airways. A LLL infiltrate is also reported. The critique, called minor but apparently this qualified as an impact on patient care, states that LLL pneumonia was not mentioned (it was) and that there was severe “bronchitis.” I do think that the mention of emphysema, COPD, and secretions in the airways in a patient known to be a smoker clearly means that “bronchitis” is present.

**OVERALL:** *The report is accurate, and no information was omitted.*

#### **QACH38 noncontrast CT, cough and SOB, 1/7/17**

The report is accurate. The important findings are reported. The criticism is that there is “large and small airways disease with air trapping.” Airway inflammation is basically always present in patients who smoke and who have emphysema and underlying small airway obstruction is also

uniform in this population. I do not see air trapping without expiratory images, which were not performed, but regardless: the patient is a smoker or former smoker with emphysema- this explains the clinical picture and I have no doubt that airway inflammation and small airway obstruction are also present- it is part of the overall smoking-related disease- reporting these things absolutely does not change management in this particular scenario.

**OVERALL:** *This report is fine. Criticism is inaccurate (air trapping seen only with expiratory images) and subjective.*

**QACH42 CT with contrast, nodule in a patient with HEENT cancer, 2/16/17**

This report is totally accurate.

The critique states that primary lung cancer is more likely than metastatic disease, and of course this is true but depends on how aggressive the HEENT cancer is and what cell type it is- this an appropriate report and stating that primary lung cancer is more likely than a metastasis absolutely does not change patient management.

The criticism that venous collaterals were not mentioned is interesting. These enhanced veins are the normal reflux of contrast down branch veins from a rapid contrast injection.

**OVERALL:** *This report is fine. The criticism is both unfounded and inaccurate.*

**QACH50 CT with contrast, chest wall pain, 1/10/2017**

This is a complex case and the discrepancies were minor and had no bearing on management. If this becomes important later, we can look more closely.

**OVERALL:** *No significant discrepancies on a complex case.*

\* \* \*

The reports of the other radiologists' reads at Marlborough Hospital, however, contain numerous typographical errors, and several have interpretive errors. My findings suggest that more thorough, consistent, and unbiased peer review and quality improvement projects are needed for the other radiologists who were involved in these cases.

Specific analysis of cases interpreted by radiologists other than Dr. Desai at Marlborough Hospital follows.

**QACH22 noncontrast CT to follow a lung nodule**

The Findings section states that the larger peripheral nodule has increased in size, and reports another nodule but does not give a measurement or image number (both of which should be provided). In the Impression, it states that the larger peripheral nodule is stable and the more central nodule has increased 1-2 mm in size. This contradicts the statement in the Findings section. In addition, measurement error is generally considered 1-2 mm on CT of nodules, so a 1-2 mm difference would not be considered significant. The report describes “biapical fibrous change.” This actually appears consistent with an entity called pleuroparenchymal fibroelastosis (PPFE), which is not mentioned.

**OVERALL:** *The Findings and Impression sections are contradictory, and the nodules are not thoroughly reported or measured.* The entity of PPFE was not suggested.

### **QACH23 noncontrast CT to follow a lung nodule**

This exam shows a few tiny nodules (that were reported previously and have not changed) that all have a typical benign appearance. The appearance, coupled with the stability since the priors, should indicate that these are benign and require no follow-up. Instead, the entire Fleischner Guidelines are attached to the report with follow-up recommendations. This is cumbersome for the patient and referring doctor to read and is also unnecessary.

**OVERALL:** *The nodules on CT have a benign appearance and the report should have stated that no follow-up was needed.*

### **QACH24 noncontrast CT to follow lung nodules**

The impression states that the patient has “scattered” apical cystic disease. This CT is actually a classic example of paraseptal emphysema and bullous disease and not cystic lung disease. “Cystic lung disease” implies a whole different set of pulmonary disorders for which the diagnostic evaluation can be costly and possibly invasive (and here, unnecessary).

**OVERALL:** *The incorrect impression of cystic lung disease affects differential diagnosis and patient management.*

### **QACH25 noncontrast CT to follow lung nodules**

The report describes stable tiny nodules (seen previously) and correctly states that no follow-up is needed. However, there are typos in the report, including in the Findings section where the location of the nodules is specified. This is not an acceptable report. In addition, unnecessary added tests (ultrasound of the gall bladder and kidney) were recommended for simple gallstones and renal cysts-no added imaging needed to be done.

**OVERALL:** *Significant typographical errors in the description of the nodules and their location- the impression of benign nodules is correct, but typos in the key sections of a*

*radiology report are careless and sloppy. Unnecessary added testing was recommended for benign findings.*

#### **QACH46 CT with contrast to assess for pulmonary embolism (PE)**

Emboli are reported but again, in BOTH the Findings and Impression sections, there are significant typographical errors in the description of the emboli and their location. This is indefensible as these are critical findings and these errors are extensive. This indicates that the radiologist clearly does not proof reports before signing them, and this type of report is well outside the standard of care. In addition, these small emboli would be unlikely to cause right heart strain as reported: the right ventricle is not definitely dilated. Reporting emboli with right heart strain can significantly affect patient management leading to possibly unnecessary aggressive therapy. This finding was best omitted from the report or perhaps a cardiac echo should have been recommended to assess the equivocal right heart prominence.

**OVERALL: *Typos in both the Findings and Impression section make the report incoherent. These are urgent findings that must be accurately documented. Here, the errors occur in two separate parts of the same report. This is again sloppy and well outside the standard of care.***

In general, these radiologists do not have guidelines regarding how to structure a proper, clinically useful CT report. There is no consistency in how the reports are structured. There is little or no attention to detail in terms of proper description of abnormalities and many findings are poorly or inaccurately reported. Typos (and retained brackets from pre-filled templates) are rampant; punctuation is essentially nonexistent. These reports come across as hurried, careless, and sloppy and are often not accurate. A much more intensive QA with remediation is warranted.

\* \* \*

Although not read at Marlborough Hospital, I also wanted to make a specific notation with regard to QACH 20:

#### **QACH20 NONCONTRAST CT FOR DYSPNEA AND POSSIBLE TRACHEOBRONCHOMALACIA**

The report in this case is far outside any standard. First, the clinical order specifically requested inspiratory and expiratory imaging to assess for suspected tracheobronchomalacia. The inspiratory/expiratory CT technique was not mentioned in the technique description of the report (although it was in fact performed), and the images actually DO SHOW this pathologic condition with collapse of the central airways on the expiratory imaging and areas of air trapping also on expiration, hallmarks of this diagnosis. Instead, the report mentions “no evidence of

tracheobronchial calcinosis.” This is a totally different entity and was not part of the clinical indication- this entity is insignificant and causes no symptoms. These errors show a fundamental failure of understanding of the indication for the scan, the technique used, and the findings of the pathologic entity. Even worse, read the report in the Findings section under the sub-heading “Lungs.” This is absolute gibberish- part of this appears to be a section of a report on a totally different examination for a different patient, and the section is filled with typos and incoherent sentence structure. Obviously, the radiologist also failed to proofread the report prior to signing it.

***OVERALL: This report is a disaster in every way. The clinical question was ignored, there is no mention of the collapse of the airways or air trapping (which are key to the real diagnosis in this case), the report is filled with significant typographical errors, and the significant pathology was totally missed. The radiologist obviously does not know what tracheobronchomalacia is or what the findings are, and he or she did not bother to look it up or ask someone else- this is sloppy, careless, unprofessional, and unacceptable. A report like this at my institution would result in immediate disciplinary action.***

#### IV. Expert Opinions

Based on my interpretation of the CT scan images and corresponding reports, which were listed in the over-reviewer’s findings as containing misreads by Dr. Desai, I have formed an opinion to a reasonable degree of certainty that Dr. Desai made no significant errors of interpretation and no errors in reporting. Certainly there are, therefore, no errors that would affect immediate patient management or outcome and/or that would justify termination.

Based on my interpretation of the CT scan images and corresponding reports, which were listed in the over-reviewer’s findings as having been read by radiologists other than Dr. Desai at Marlborough Hospital, I have formed an opinion to a reasonable degree of certainty, that those reports contain numerous, significant, and inexplicable typographical errors and several significant interpretive errors. Other reports recommended unnecessary additional imaging examinations to evaluate insignificant findings. The reports of those studies conducted by other radiologists fell outside a reasonable standard.

Finally, based on my experience as a radiologist at a major hospital and the apparent methodology of the instant review (i.e., that all of the cases were submitted in a small window in early 2017), I have formed an opinion to a reasonable degree of certainty, that the method of peer review used in this case does not conform to any appropriate or well-known guidelines for a fair peer review process.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY ON THIS DAY OF  
JULY 28, 2021.

  
James F. Gruden, M.D.

# Exhibit A

Revised: 6/1/21

## **A. GENERAL INFORMATION**

**Name:** James Franklin Gruden

**Office Address:** 525 E 68 Street, Box 141, Room L-019, NY, NY 10065

**Home Address:** [REDACTED]

**Cell Phone:** [REDACTED]

**Email:** jfg9007@med.cornell.edu

**Citizenship:** USA

**Date of Birth:** 07/16/60

**Place of Birth:** Sandusky, OH

**Marital Status:** Single

**Race:** Caucasian

## **B. EDUCATIONAL BACKGROUND**

Certificate, Executive Healthcare Management  
E-Cornell, 2021

MD University of Miami  
Miami, FL  
09/83-05/87  
MD, 1987

BA University of Notre Dame  
Notre Dame, IN  
08/79-05/83  
BA, Economics and Preprofessional Studies, 1983

## **C. PROFESSIONAL POSITIONS AND EMPLOYMENT**

### **POSTDOCTORAL TRAINING**

Fellow, Thoracic Imaging  
University of California-San Francisco  
San Francisco, CA  
Directors: W. Richard Webb, MD and Gordon Gamsu, MD  
07/01/92-06/30/93

Resident, Diagnostic Radiology  
New York Hospital -Cornell Medical Center and Cooperating Hospitals  
New York, NY

07/01/88-06/30/92

Intern, Internal Medicine  
Cabrini Medical Center- New York Medical College  
New York, NY  
07/01/87-06/30/88

## **ACADEMIC POSITIONS**

Professor of Clinical Radiology  
Weill Cornell Medicine  
New York, NY  
01/11/15-present

Associate Professor of Radiology  
Mayo Clinic College of Medicine  
Phoenix-Scottsdale, AZ  
10/02/04-1/10/15

Adjunct Professor of Biomedical Engineering  
Georgia Institute of Technology  
Atlanta, GA  
07/01/02-10/01/04

Associate Professor of Radiology and Internal Medicine  
Emory University School of Medicine  
Atlanta, GA  
01/02/00-10/01/04

Assistant Professor of Radiology  
NYU School of Medicine  
New York, NY  
11/01/95-01/01/00

Assistant Professor of Radiology in Residence  
University of California-San Francisco School of Medicine  
San Francisco, CA  
07/01/93-10/31/95

## **HOSPITAL POSITIONS**

Attending Radiologist  
Division Director, Cardiothoracic Imaging  
New York Presbyterian-Weill Cornell Medical Center  
New York, NY

01/11/15-present

Attending Radiologist  
Division Director, Body and Cardiothoracic Imaging  
New York Presbyterian-Weill Cornell Medical Center  
New York, NY  
01/11/15-01/01/2020

Consultant Radiologist  
Director, Cardiothoracic Imaging  
Mayo Clinic and Mayo Clinic Hospital  
Phoenix-Scottsdale, AZ  
10/01/07-01/10/15

Senior Associate Consultant Radiologist  
Mayo Clinic and Mayo Clinic Hospital  
Phoenix-Scottsdale, AZ  
10/02/04-10/01/07

Attending Radiologist  
Division Director, Cardiothoracic Imaging  
Director, Biomedical Imaging Laboratory  
Emory University Hospital and Clinic  
Atlanta, GA  
01/02/00-10/01/04

Attending Radiologist  
NYU Medical Center  
Bellevue Hospital Center  
New York, NY  
11/01/95-01/01/00

Attending Radiologist  
Chief, Thoracic Imaging  
San Francisco General Hospital  
San Francisco, CA  
07/01/93-10/31/95

#### **D. LICENSURE, BOARD CERTIFICATION, MALPRACTICE**

##### **LICENSES**

New York	174823 (active)
North Carolina	2021-01926 (active)
Arizona	33278

Florida ME89033  
California G73732  
Georgia 046967

DEA Number: BG3334466 (active)

## **BOARD CERTIFICATION**

Diplomate, American Board of Radiology 1992 (MOC participant)  
Diplomate, National Board of Medical Examiners 1988

## **MALPRACTICE INSURANCE**

MCIC of Vermont  
Premiums paid by: Weill Cornell Medicine

## **E. PROFESSIONAL MEMBERSHIPS**

American College of Radiology  
Society of Thoracic Radiology  
American College of Chest Physicians  
American Roentgen Ray Society  
Radiologic Society of North America

## **F. HONORS AND AWARDS**

Editor's Recognition Award "With Distinction"  
Manuscript Reviews, *Radiology*  
1994, 1995, 1996, 1997, 1999

Valedictorian  
University of Miami School of Medicine, Miami, FL  
1987

Alpha Omega Alpha Honor Society  
University of Miami Chapter, Miami, FL  
1986, 1987

Graduation With Highest Honors  
University of Notre Dame, Notre Dame, IN  
1983

Phi Beta Kappa  
University of Notre Dame Chapter, Notre Dame, IN  
1983

## **G. INSTITUTIONAL/HOSPITAL AFFILIATION**

1. Primary Hospital Affiliation: New York Presbyterian-Weill Cornell Medical Center
2. Other Hospital Affiliations: New York Presbyterian-Lower Manhattan Hospital, Brooklyn Methodist Hospital
3. Other Institutional Affiliations: None

## **H. EMPLOYMENT STATUS**

1. Current employer: Weill Cornell Medicine
2. Employment status: Full time salaried by Weill Cornell Medicine

## **I. CURRENT AND PAST INSTITUTIONAL RESPONSIBILITIES AND CURRENT PERCENT EFFORT**

### **Teaching 10% effort**

#### *Medical Students:*

##### Weill Cornell:

Participate in the active teaching and engagement of students of all levels on Chest Radiology

##### Emory:

Directed and supervised all elective Cardiothoracic Imaging rotations for senior students

##### UCSF:

Monthly didactic lectures on chest radiology to third and fourth year students

#### *Residents:*

##### Weill Cornell:

Direct the top-ranked rotation by residents (now five consecutive years)

Responsible for Cardiothoracic and Body Imaging rotation structure, content (Cardiothoracic only after 1/01/2020)

Daily CT and radiograph readout with residents on Cardiothoracic Imaging rotation

Didactic lectures to Pulmonary Medicine residents and fellows

Participate in didactic Cardiothoracic conference series

##### Mayo Clinic Arizona:

Didactic monthly lectures to residents (new residency began 2014)  
Daily readout CT and chest radiographs with residents on service (final 4 months only)

Emory:

Redesigned the Radiology Resident rotations (4 residents each month)  
Instituted a Cardiac Imaging rotation for senior residents  
Instituted "Imaging" as a monthly session in the Pulmonary Medicine Conference series  
Daily CT and Chest film readout with residents  
Twice monthly noon conferences  
Formal lecture series on Cardiothoracic Imaging  
Board Review sessions to fourth year residents scheduled each spring  
Supervised all Cardiothoracic Imaging rotations and electives

NYU:

Daily CT and chest film readout with residents, Bellevue Hospital Center  
Didactic resident conferences 6-8 times per year  
Board review conferences each spring

UCSF:

Daily CT, Chest film readout with residents  
Didactic conferences weekly to residents at San Francisco General Hospital  
Board Review sessions (at least 3 per year) for fourth year residents  
Participant, annual Mock Oral Boards Examination

### **Clinical Care 60% effort**

Weill Cornell:

Redesigned all rotations in Body and Cardiothoracic Imaging  
Lead Radiologist in weekly multidisciplinary Thoracic Oncology Conference  
Lead Radiologist in weekly Pulmonary Medicine Conference  
Lead Radiologist in monthly Interstitial Lung Disease CT/Pathology Conference  
Took over CT/PET Service for primary chest malignancies  
Initiated remote reading of Chest CTs from NYP-Brooklyn Methodist  
Established remote read from home options for the Division  
Redigned and constantly update Chest CT protocols at inpatient and outpatient sites  
Responsible for all aspects of daily clinical Body (until 1/01/2020) and Cardiothoracic Imaging Services  
Established the Lung Nodule Consult Service for outpatients  
Co-direct the Lung Cancer Screening Program  
Supervise all aspects of clinical scheduling  
Growth from 2 to 9 full time Cardiothoracic radiologists (and 3 Cardiology imagers)  
Completely built the Cardiothoracic Imaging Division that currently exists

Mayo Clinic Arizona:

Redesigned workflow and created technologist-driven protocols

Chest and cardiac CT protocols, quality control, and interpretation  
Implemented routine workstation use in CT with PACS integration  
Involved with planning, staffing, recruitment and did all clinical scheduling  
Oversaw growth from 2 to 6 full time Cardiothoracic radiologists  
Established flexible scheduling that spread to the rest of the Department

Emory:

Inherited a service that interpreted plain films only  
Instituted lung cancer and coronary calcification screening programs  
Established and led weekly multidisciplinary Chest Conference Thursday mornings  
Developed all Chest CT protocols at Emory University Hospital and Clinic  
Complete control over Divisional scheduling and workflow  
Established flexible scheduling for the section  
Founder, Biomedical Imaging Lab  
Established financial independence of the Imaging Lab  
Established Emory as the first Luminary Site for Image Processing (GE)  
Established office space at Georgia Tech BME with link to Imaging Lab  
Built the comprehensive Cardiothoracic Imaging service that exists at Emory today

NYU:

Designed and implemented computerized database for Chest Radiology Section  
Participated in daily ICU radiology conference, Bellevue and NYU Medical Center  
Redesigned clinical coverage schedules

UCSF:

Ran the Chest Radiology Service independently at San Francisco General Hospital  
Participated in daily Pulmonary Medicine Work Rounds  
Participated in weekly Pulmonary Medicine Conference  
Performed all intrathoracic interventions

**Administrative duties 10% effort**

Weill Cornell:

Director Cardiothoracic Imaging 2015-present  
Director, Body Imaging 2015-2020  
Program Education Committee  
Executive Committee (all Division Directors and the Chair)  
Committee of Review (Promotions Committee)  
Resident Selection Committee

Mayo Clinic Arizona:

Education Committee (2104-departure)  
Director, Cardiothoracic Imaging (2007-2012, time-limited)

Emory:

Director, Cardiothoracic Imaging  
Director and Founder, Biomedical Imaging Lab (BIL), Emory/Georgia Tech  
New Horizons Committee  
Finance Committee  
Resident Review Committee  
Executive Committee

NYU:

Utilization Management Team Leader, Radiology Reengineering Project (1997-1999)

UCSF:

Chief, Thoracic Imaging Section, San Francisco General Hospital  
Clinical Practice Guidelines Committee, San Francisco General Hospital (1995-1996)  
General Clinical Research Center Advisory Committee, San Francisco General Hospital (1994-departure)  
Radiology Resident Selection Committee, University of California-San Francisco (1993-departure)

### **Research interests 20% effort**

Primary experience is in the area of cardiothoracic CT, CT protocol optimization, and CT image post-processing. Specific interests center on high-resolution imaging of diffuse lung disease and the imaging findings in infiltrative lung disease, imaging of the pulmonary vasculature, and lung cancer screening and post-treatment assessment. Other activities and interests include workflow optimization, clinical operations, and involvement of the radiologist in direct patient communication. Recently, enjoy focusing on problems and pitfalls in current trend to rely solely on “expert” consensus recommendations as the foundation for practice without critical analysis. Currently focused on long-term pulmonary sequelae of Covid-19 infection.

### **J. RESEARCH SUPPORT**

2021: Co-Investigator and Lead Radiologist, Boehringer-Ingelheim Clinical Study  
COVID-related Pulmonary Complications  
Lead Investigator: Rob Kaner MD  
Funded 20% salary support for one year  
Weill Cornell Medicine

2012: PI MCA 1542-11

Low dose CT with MBIR in the assessment of diffuse lung disease: comparison with conventional high resolution images (5% salary support)  
General Electric Medical Systems  
Mayo Clinic Arizona

2004: PI General Electric Medical Systems Grant  
Coronary CTA-Cardiac Catheterization Correlative Imaging  
Funded for 3 years, direct costs \$150,000  
Emory University Department of Radiology

2001: PI Coulter Foundation Biomedical Engineering Grant  
CAD in the Detection of Pulmonary Nodules  
Funded for 1 year, direct costs \$100,000  
Emory University Department of Radiology  
Biomedical Imaging Lab

1995: CoPI AIDS Clinical Research Center Grant  
CT of the thymus in HIV-infected patients: comparison to normal controls  
Funded for 1 year, total costs \$20,000  
University of California-San Francisco School of Medicine

1994: PI Society of Thoracic Radiology Seed Grant  
HRCT in HIV infected patients after negative sputum induction for PCP  
Funded for 1 year, total costs \$12,000  
University of California-San Francisco School of Medicine

## **K. EXTRAMURAL PROFESSIONAL RESPONSIBILITIES**

### **Committees:**

Body Imaging Economics Committee  
American College of Radiology, 2016-2018  
**Chair, 2018-present**

MOC Exam Question Editor  
American Board of Radiology, Thoracic Imaging  
**2018-present** (renewed 3-year term 2020)

Member, STR Health and Wellness Committee  
**2019-present**

Diagnostic Radiology Exams Standard-Setting Committee  
American Board of Radiology  
2019

MOC Exam Question Writer  
American Board of Radiology, Thoracic Imaging  
2017-2018

### **Manuscript and Abstract Reviewer:**

*AJR*, 1992-2004, 2015-present  
*Journal of Thoracic Imaging*, 2015-present  
*European Radiology*, 2019-present  
*Chest*, 2019-present  
*American Journal of Respiratory and Critical Care Medicine*, 2019-present  
Abstract reviewer, American Roentgen Ray Society Annual Meeting, 2014-present  
*Clinical Imaging*, 2015-2018 (Section Editor, Cardiothoracic Imaging)  
*Radiology*, 1992-2003

**NIH Study Sections:**

2005:

NIH Grant Reviewer  
RFA-HL-04-031  
HIV and the Lung

2002:

Special Emphasis Panel, National Heart, Lung and Blood Institute  
National Institutes of Health, Washington DC  
RFA HL-02-005  
Novel Biomarkers of Chronic Obstructive Pulmonary Disease

2001:

Special Emphasis Panel, National Heart, Lung, and Blood Institute  
National Institutes of Health, Washington DC  
RFP NHLB-HR-01  
Severe Asthma Consortium Development

1999:

Special Emphasis Panel, National Heart, Lung, and Blood Institute  
National Institutes of Health, Washington DC  
RFP NHLB-HR-99-01  
Clinical Centers for Feasibility Studies on Retinoid Treatment of Emphysema

**Invited Lectures:**

2021: American College of Chest Physicians  
“CT in Fibrotic ILD Part 1”  
“CT in Fibrotic ILD Part 2”  
“CT in Acute Pulmonary Embolism”  
To be recorded as Enduring Educational Content for ACCP Members

2021: American Roentgen Ray Society Annual Meeting

“Improving the Diagnosis of UIP”  
Virtual live stream due to CoVID-19

2020: American College of Chest Physicians  
“CT in the Diagnosis of PFILD”  
Virtual live webinar due to CoVID-19

2020: American Roentgen Ray Society Annual Meeting  
“CT in the Diagnosis of UIP: Outside the Guidelines”  
To be recorded due to COVID-19

2020: Society of Thoracic Radiology Annual Meeting  
“CT in the Diagnosis of UIP: Improving the Existing Guidelines”  
Recorded due to COVID-19

2020: Cardiothoracic Imaging Society of New York  
“CT Observations in Fibrotic ILD”  
New York, NY

2020: Columbia University, Visiting Professor  
“The Incidental Lung Nodule”  
“Current Chest Cases of Interest”  
New York, NY

2019: John Evans Annual Symposium, Weill Cornell Medicine  
“Radiology Taking Responsibility: the Incidental Nodule Clinic”  
New York, NY

2019: Long Island Radiologic Society  
“CT in Fibrotic Lung Disease”  
Jericho, NY

2019: Multidisciplinary Pulmonary Pathology Course  
Memorial Sloan Kettering Cancer Center  
“CT and Interstitial Fibrosis: UIP, CHP, NSIP”  
New York, NY

2019: Hyman Senturia 25<sup>th</sup> Annual Memorial Lecture  
“CT in Progressive-Fibrotic Interstitial Lung Disease (P-FILD)”  
Mallinckrodt Institute of Radiology  
St. Louis, MO

2019: Symposium on the Diagnosis and Management of Lung Cancer  
American College of Chest Physicians Course

“The Incidental Nodule: Fleischner Applications”  
“Issues in Imaging: Non-solid Nodules, CT/PET, and Lung-RADS”  
“Cases and Tumor Board”  
Chicago, IL

2018: Symposium on the Diagnosis and Management of Lung Cancer  
American College of Chest Physicians Course  
“The Incidental Nodule: Fleischner Applications”  
“Issues in Imaging: Non-solid Nodules, CT/PET, and Lung-RADS”  
“Cases and Tumor Board”  
Chicago, IL

2017: American Roentgen Ray Society Annual Meeting  
Categorical Course Speaker  
“CT and the Incidental Lung Nodule”  
Washington, DC

2017: Society of Thoracic Radiology Annual Meeting  
“Dendriform Pulmonary Ossification”  
Austin, TX

2016: American Roentgen Society Annual Meeting  
Invited Keynote Speaker  
“Improving the Diagnosis of UIP”  
Los Angeles, CA

2016: Society of Thoracic Radiology Annual Meeting  
“Holes in the Lung: Time to Revisit Old Definitions”  
Scottsdale, AZ

2015: Society of Thoracic Radiology Annual Meeting  
“Improving the radiologic diagnosis of UIP”  
Carlsbad, CA

2014: Mayo Clinic Imaging Course and Self-Assessment Course  
“CT and Pulmonary Arterial Hypertension”  
“Interesting Thoracic CT Cases”  
Laguna Niguel, CA

2014: Educational Symposia (ESI) Meeting  
“CT of idiopathic interstitial lung disease”  
“CT of PE: new observations”  
“Non-neoplastic smoking-related lung disease”  
Aspen, CO

2014: CT International Symposium  
"CT of idiopathic interstitial lung disease"  
"CT and pulmonary hypertension"  
"Smoking-related lung disease"  
"Case based approach to interstitial lung disease"  
Madrid, Spain

2013: Golnick Symposium Lectures  
"CT and the diagnosis of UIP/IPF: diagnostic features"  
Lake Bled, Slovenia

2012: Radiology International Course  
"Radiation dose reduction strategies in cardiothoracic CT"  
"Smoking-related lung disease"  
"Coronary CTA"  
"Clinical cardiac MRI"  
"Cardiothoracic cases"  
Valencia, Spain

2011: Mayo Clinic Diagnostic Radiology Course  
"CT and interstitial lung disease"  
"Interesting chest cases"  
Laguna Niguel, CA

2010: UCSF Diagnostic Imaging Course  
"Cardiothoracic CT cases"  
"Coronary CTA: how and when"  
"Non-neoplastic smoking-related lung disease"  
"CT of interstitial lung disease"  
Cancun, Mexico

2008: RSNA  
Refresher Course: Emerging technologies  
"MDCT: after the scan"  
Chicago, IL

2008: IAME Medical Meetings  
"Pitfalls in cardiac CT"  
"Cardiac CT: urgent or emergent?"  
"MDCT of pulmonary embolism"  
"Pulmonary hypertension: the role of MDCT"  
Las Vegas, NV

2008: Orange County (CA) Radiology Society  
"CT of idiopathic ILD"

“Cardiac CT: urgent or emergent?”  
“Management of the solitary lung nodule”  
Irvine, CA

2007: North American Society of Cardiac Imaging (NASCI)  
“Pitfalls in coronary CTA interpretation”  
Washington, DC

2007: Educational Symposia (ESI)  
Cardiovascular CT  
“Cardiac CT: urgent or emergent?”  
“Pulmonary arterial hypertension”  
“Cardiac CT postprocessing and data management”  
Las Vegas, NV  
2007: RSNA  
Refresher Course: Emerging technologies  
“MDCT: after the scan”  
Chicago, IL

2007: American College of Chest Physicians (ACCP) Review Course  
“Chest radiology I”  
“Chest radiology II”  
Scottsdale, AZ

2007: American Roentgen Ray Society  
“Clinically relevant thoracic CT postprocessing”  
Orlando, FL

2007: Italian Congress on Interstitial Lung Disease  
“HRCT: patterns and diagnoses”  
“Radiologic approaches to ILD”  
Rome, Italy

2007: Educational Symposia (ESI)  
Cardiovascular CT  
“Cardiothoracic CT in the ER”  
“CT and pulmonary embolism: new observations”  
“Pulmonary arterial and venous hypertension”  
Vail, CO

2007: Mayo School of Continuing Education  
Updates in Imaging  
“ILD: CT-pathologic correlates”  
“Non-neoplastic smoking-related lung disease”  
Kona, HI

2006: Mayo School of Continuing Education  
Update in Rheumatology  
“HRCT in connective tissue disorders”  
Victoria, BC, Canada

2006: Symbion Healthcare Annual Meeting  
“Cardiac CT Part One: Acquisition”  
“Cardiac CT Part Two: Interpretation”  
“MDCT of pulmonary embolism: new observations”  
Gold Coast  
Queensland, Australia

2006: RSNA  
Refresher Course  
“Post-processing MDCT data sets: applications”  
Chicago, IL

2006: American Roentgen Ray Society  
“Clinically relevant thoracic CT postprocessing”  
Vancouver, BC, Canada

2006: Mayo School of Continuing Education  
Multidisciplinary Update in Pulmonary and Critical Care Medicine  
“MDCT of the airways”  
Scottsdale, AZ

2006: Society of Thoracic Radiology  
“Coccidioidomycosis”  
Orlando, FL

2006: NYU Department of Radiology  
Body Imaging in the Caribbean  
“Pulmonary hypertension”  
“CT and the diagnosis of thrombo-embolic disease”  
“Interstitial lung disease: radiologic-pathologic correlation”  
“Chest CT cases”  
St. John, US Virgin Islands

2005: Stanford University Symposium on Multidetector CT  
Workstation Showdown Presenter  
General Electric Advantage Windows Workstation  
San Francisco, CA

2005: Mayo School of Continuing Education  
Multidisciplinary Update in Pulmonary and Critical Care Medicine  
"Role of CT angiography in acute and chronic pulmonary embolic disease"  
Scottsdale, AZ

2005: Society of Body Computed Tomography Annual Meeting  
Workstation Showdown Presenter  
General Electric Advantage Windows Workstation  
Miami Beach, FL

2005: University of California (Davis)  
3D Imaging Amongst the Temples  
"Thoracic CTA: acute PE and aortic disease"  
"Thoracic CTA: pulmonary arterial and venous hypertension"  
"Cardiothoracic image processing tools"  
Cancun, Mexico

2005: American Roentgen Ray Society Annual Meeting  
Categorical Course, Cardiopulmonary Imaging  
"Pulmonary CTA: Techniques and Pitfalls in Interpretation"  
New Orleans, LA

2005: Yale University School of Medicine  
Radiology Grand Rounds  
"CT of Pulmonary Thrombo-embolic Disease: New Concepts"  
New Haven, CT

2005: Long Island College Hospital  
Radiology Grand Rounds  
"CT of Pulmonary Embolism: Techniques and Pitfalls"  
Brooklyn, NY

2004: Boston University School of Medicine  
Radiology Grand Rounds  
"Cardiothoracic Image Processing Applications"  
Boston, MA

2004: Bridgeport Hospital-Yale New Haven Health System

Radiology Grand Rounds  
"Cardiac MDCT Techniques and Future Applications"  
Bridgeport, CT

2004: Educational Symposia (ESI)  
Cardiovascular CT 2003: What You Need to Know  
"Image processing tools"  
"Pulmonary arterial and venous hypertension"  
Las Vegas, NV

2004: National Conference on Venous Thromboembolism  
GE Medical Systmes-Asia  
"MDCT of Acute and Chronic Pulmonary Embolism"  
Beijing, China

2004: Stanford University Symposium on Multidetector CT  
"How workstations have changed the way I read images"  
San Francisco, CA

2004: American Roentgen Ray Society Annual Meeting  
Refresher Course Speaker  
"MDCT of pulmonary thromboembolism"  
Miami Beach, FL

2004: Society of Thoracic Radiology  
"Image processing applications in the thorax"  
Rancho Mirage, CA

2004: University of California (Davis)  
3D Imaging Amongst the Temples  
"Thoracic CTA: acute PE and aortic disease"  
"Thoracic CTA: pulmonary arterial and venous hypertension"  
"Cardiothoracic image processing tools"  
"CT coronary assessment: calcium and contrast"  
Cancun, Mexico

2004: Emory University School of Medicine  
Radiology Grand Rounds  
"Cardiac MDCT: calcium scoring and beyond"  
Atlanta, GA

2003: Educational Symposia (ESI)  
Cardiovascular CT 2003: What You Need to Know

"Image processing tools"  
"Pulmonary arterial and venous hypertension"  
"Cariopulmonary MDCT cases"  
Las Vegas, NV

2003: American Roentgen Ray Society Annual Meeting  
Refresher Course Speaker  
"Multi-detector pulmonary CTA"  
San Diego, CA

2003: American Roentgen Society Annual Meeting  
General Electric Medical Systems Seminar  
"3D Imaging: enhancing the radiologist-clinician relationship"  
San Diego, CA

2003: Insitiute for Advanced Medical Education (IAME)  
Clinical Essentials of CT and MRI  
"Workstation applications in thoracic CT"  
Hands-On Workstation Training Sessions  
Las Vegas, NV

2003: Society of Thoracic Radiology Annual Meeting  
"Multi-detector CT angiography"  
Miami Beach, FL

2002: Solitary Pulmonary Nodule Working Seminar  
"Dynamic CT of pulmonary nodules"  
"Case studies: functional assessment of the SPN"  
Banff, Alberta, Canada

2002: American Roentgen Ray Society Annual Meeting  
Refresher Course Speaker  
"Multi-channel CT and venous thromboembolic disease: new directions"  
Atlanta, GA

2001: Brown University School of Medicine  
Radiology Grand Rounds  
"MDCT in lung nodule detection: new applications"  
Providence, RI

2001: Southeastern Interventional Radiology Society  
"MDCT in pulmonary embolism"  
Atlanta, GA

2001: Educational Symposia (ESI)

Multislice CT

"MDCT in nodule detection"

"MDCT in nodule characterization"

"HRCT with MDCT: concepts of diagnostic accuracy"

New York, NY

2001: Society of Thoracic Radiology Annual Meeting

"MDCT in pulmonary embolism: new applications"

Boca Raton, FL

2001: Emory University School of Medicine

Radiology Grand Rounds

"MDCT in pulmonary embolism"

Atlanta, GA

2000: Emory University School of Medicine

Surgery Grand Rounds

"CT in pulmonary embolism"

Atlanta, GA

2000: Albert Einstein School of Medicine

Radiology Grand Rounds

"Nodule localization on HRCT"

Bronx, NY

2000: Montefiore Medical Center

Radiology Grand Rounds

"Nodule localization on HRCT"

Bronx, NY

2000: Mt. Tabor (Brazil) School of Medicine

Seminars in Pulmonology

"HRCT: anatomy and terminology"

"Pulmonary infections"

"Pulmonary embolism: imaging tools"

"HRCT: specific diagnoses and diagnostic accuracy"

Salvador, Bahia, Brazil

2000: UCSF Department of Radiology

Body Imaging with CT and MRI

"CT in 'R/O PE': application and interpretation"

"Pitfalls in HRCT interpretation"

"CT-HRCT assessment of nodular lung disease"

"UIP, DIP, IPF, BOOP, BO, NSIP, ETC."

Palm Springs, CA

1999: Maine Medical Center  
Kjeldgaard Seminar on Interstitial Lung Disease  
"Concepts of accuracy of HRCT in interstitial lung disease"  
"Nodule localization on HRCT"  
Portland, ME  
1999: NYU Department of Radiology  
CT and MRI Head-to-Toe  
"Can HRCT obviate lung biopsy?"  
"Nodule localization on HRCT"  
New York, NY

1999: Society of Thoracic Radiology Annual Meeting  
"Nodule localization algorithm using HRCT"  
Amelia Island, FL

1999: Mt. Sinai Medical Center  
Occupational Medicine Grand Rounds  
"Use of HRCT in pneumoconiosis"  
New York, NY

1999: Mt. Sinai Medical Center  
Pulmonary Medicine Grand Rounds  
"Can HRCT obviate biopsy?"  
New York, NY

1999: Thomas Jefferson Medical College  
Radiology Grand Rounds  
"Nodule localization on CT/HRCT"  
Philadelphia, PA  
1998: NYU Department of Radiology  
Postgraduate Radiology in Puerto Rico  
"Clinical indications for HRCT"  
"Pitfalls in HRCT interpretation"  
"CT of focal lung disease"  
Dorado, PR

1998: NYU Department of Radiology  
CT and MRI Head-to-Toe  
"HRCT: Can it obviate lung biopsy?"  
"Nodule localization on CT/HRCT"  
New York, NY

1998: UCSF Department of Radiology  
Body Imaging in Paradise  
"How to read HRCT"

"Pitfalls in HRCT interpretation"  
"CT of the airways: large and small"  
"CT of focal lung disease"  
Kona, HI

1998: New York Roentgen Society Spring Conference  
"Pitfalls in HRCT Interpretation"  
New York, NY

1997: International Infectious Disease Congress  
"Use of HRCT in AIDS"  
"Imaging the complications of HIV disease: new observations"  
"Imaging of pleuroparenchymal infections"  
"Imaging in AIDS"  
Rosario, Argentina

1997: NYU Department of Radiology  
CT and MRI Head-to-Toe  
"CT/HRCT in AIDS"  
"Pitfalls in HRCT interpretation"  
New York, NY

1997: UCSF Department of Radiology,  
Body Imaging in Paradise  
"Helical CT of the airways"  
"CT/HRCT of nodular lung disease"  
"HRCT: pattern approach"  
"Applications of helical CT including embolic disease"  
"Radiology in the world of managed care"  
Kona, HI

1997: Montefiore Medical Center and Jacobi Medical Center  
Albert Einstein University School of Medicine  
Radiology Grand Rounds  
"Pitfalls in HRCT interpretation"  
Bronx, NY

1997: Emory University Department of Radiology  
Radiology Grand Rounds  
"Classics in chest CT"  
Atlanta, GA

1996: Society of Thoracic Radiology Annual Meeting  
"AIDS-related neoplasms"  
Kona, HI

1996: UCSF Department of Radiology  
Diagnostic Radiology Seminars  
"Pulmonary complications of AIDS"  
"CT of nodular lung disease"  
"Pleuroparenchymal infections"  
"CT of the airways"  
"Basic HRCT Interpretation"  
Maui, HI

1996: New York Roentgen Society Spring Conference  
"Noninfectious complications of AIDS"  
New York, NY

1996: UCSF Department of Radiology  
Body Imaging in Paradise  
"Utility of HRCT and interpretive pitfalls"  
"CT of nodular lung disease"  
"CT of the airways"  
"HRCT: a simple approach to interpretation"  
Kona, HI

1996: NYU Department of Radiology  
CT and MRI Head-to-Toe  
"Chest CT utilization in HIV-AIDS"  
New York, NY

1996: UCSF Department of Radiology  
Imaging in AIDS/Trauma  
"Pulmonary Infections in AIDS"  
"AIDS-related neoplasms"  
"Pleuroparenchymal infection"  
San Francisco, CA

1996: Albany Medical College  
Radiology Grand Rounds  
"CT of the airways"  
"CT of nodular lung disease"  
Albany, NY

1995: LSU School of Medicine  
Radiology Grand Rounds  
"CT of the airways"  
New Orleans, LA

1995: Society of Thoracic Imaging Annual Meeting  
"AIDS-related thoracic neoplasms"  
Amelia Island, FL

1995: UCSF Department of Radiology  
Resident Review Course  
"Pulmonary infections"  
San Francisco, CA

1995: UCSF Department of Radiology  
Radiology Spring Training  
"HRCT findings in airways disease"  
"Imaging of chest disease in AIDS"  
"CT/HRCT and nodular lung disease"  
Phoenix, AZ

1995: South Central Kansas Radiology Society  
"Clinical utility of HRCT"  
"Imaging the thoracic complications of AIDS"  
Wichita, KS

1995: UCSF Department of Radiology,  
Annual Postgraduate Course in Diagnostic Imaging  
"Pitfalls in HRCT interpretation"  
San Francisco, CA

1995: UCSF Department of Radiology  
Imaging in AIDS and Trauma  
"Pulmonary infections in AIDS"  
"AIDS-related neoplasms"  
"Pulmonary infections in the emergency room"  
San Francisco, CA

1995: UCSF Department of Radiology  
Body Imaging in Paradise  
"HRCT: how to read it and when to do it"  
"Features and value of HRCT in airways disease"  
"Imaging and diagnosis in HIV-related chest disease"  
"CT in the evaluation of nodular lung disease"  
Kona, HI

1995: UCSF Department of Radiology  
Practical Body Imaging

"CT/HRCT in AIDS"  
Monterey, CA

**Organization of National or International Conferences:**

2021: Moderator, "Cystic Lung Disease"  
Society of Thoracic Radiology Annual Meeting  
Live Webinar due to COVID-19

2016: Moderator, Chest Scientific Sessions  
American Roentgen Society Annual Meeting  
Los Angeles, CA

2015: Moderator, "Chest Imaging" Session  
American Roentgen Ray Society Annual Meeting  
Toronto, Canada

2010: Moderator, "Thoracic Oncology" Session  
European Society of Thoracic Imaging Annual Meeting  
Bern, Switzerland

2007: Moderator, "Advanced MDCT in the Thorax" Course  
American Roentgen Ray Society Annual Meeting  
Orlando, FL

2006: Moderator, "Noncardiac Applications of Chest MDCT" Course  
American Roentgen Ray Society Annual Meeting  
Vancouver, BC, Canada

2004: Moderator, "3D and Functional Imaging" Session  
Society of Thoracic Radiology Annual Meeting, Rancho Mirage, CA

1999: Moderator, "High Resolution CT" Session  
Society of Thoracic Radiology Annual Meeting, Amelia Island, FL

1995: Course Co-Director, "Imaging in AIDS" CME Course  
University of California-San Francisco Department of Radiology

**L. BIBLIOGRAPHY**

**1. Original Articles:**

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**Gruden JF**, Green DB, Legasto AC, Jensen EA, Panse PM. Dendriiform pulmonary ossification in the absence of usual interstitial pneumonia: CT features and possible association with recurrent acid aspiration. *AJR* 2017; 209:1209-1215.

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**Gruden JF**, Panse PM, Gotway MB, Jensen EA, Wellnitz CV, Wesselius L. Diagnosis of Usual Interstitial Pneumonitis in the absence of honeycombing: evaluation of specific CT criteria with clinical follow-up in 38 patients. *AJR* 2016; 206(3):472-80.

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**Gruden JF**, Ouanounou S, Tigges S, Norris SD, Klausner TS. Incremental benefit of maximum intensity projection (MIP) images on observer detection of pulmonary nodules revealed by multidetector CT. *AJR* 2002; 179:149-157.

**Gruden JF**, Campagna G, McGuinness G. Variable CT appearance of the bronchial stump and second carina after left upper lobectomy. *J Thorac Imag* 2000; 15:138-143.

**Gruden JF**, Webb WR, Naidich DP, McGuinness G. Anatomic localization of multinodular disease on high-resolution CT (HRCT): evaluation of a simple algorithm. *Radiology* 1999; 210:711-720.

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2013:

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“Ultra-low dose CT in the assessment of diffuse lung disease: Comparison with conventional images”

Abstract and Presentation, European Respiratory Society

Barcelona, Spain

2012:

**Gruden JF**, Panse PM, Gotway MB, Wellnitz CV.

“UIP without honeycombing: HRCT features”

Abstract and Presentation, European Society of Thoracic Imaging  
London, UK

2011:

**Gruden JF**, Panse PM.

“Dendriiform pulmonary ossification: clinical correlates”

Scientific Poster and Presentation, European Respiratory Society  
Amsterdam, The Netherlands

**Gruden JF**, Panse PM.

“CT features in dendriiform pulmonary ossification”

Scientific poster and presentation, European Society of Thoracic Imaging  
Heidelberg, Germany

2010:

**Gruden JF**, Panse PM.

“Dual energy GSI (gemstone spectral imaging) in comparison to conventional dynamic  
CT in pulmonary nodule assessment: initial observations”

Abstract and Presentation, European Society of Thoracic Imaging  
Bern, Switzerland

**Gruden JF**, Panse PM, Leslie KO.

“HRCT features of UIP diagnosed at open biopsy”

Scientific Poster and Presentation, European Respiratory Society  
Barcelona, Spain

**Gruden JF**, Panse PM.

“Clinical outcomes following negative low dose CT pulmonary angiography”

Scientific Poster and Presentation, European Respiratory Society  
Barcelona, Spain

**Gruden JF**, Panse PM.

CT assessment of chest pain: a two-step approach”

Abstract, Cardiac MRI & CT Clinical Update  
Cannes, France

Panse PM, Pavlicek W, Sun L, Boltz T, Chandra N, Paden R, Hara A, **Gruden JF**

“Dual energy CT for coronary artery plaque characterization and risk stratification”

Abstract, Cardiac MRI & CT Clinical Update  
Cannes, France

2009:

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“HRCT features of UIP diagnosed at surgical lung biopsy:1999-2009”

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San Diego, California

2002:

Pearlman H, **Gruden JF**, Gal A.

“Dynamic CT nodule enhancement v. PET in the assessment of the SPN: preliminary results”

Abstract, American Roentgen Ray Society Scientific Session

Atlanta, GA

2001:

**Gruden JF**, Tigges S, Norris SD, Ouanounou S, Klausner T.

“Incremental value of MIP images on observer detection of pulmonary nodules”

Abstract and Presentation, Society of Thoracic Radiology Scientific Session

Boca Raton, FL

Ouanounou S, Tigges S, Norris SD, Klausner T, **Gruden JF**.

“Incremental benefit of MIP imaging in pulmonary nodule detection with multislice CT”

Scientific Poster, American Thoracic Society

San Francisco, CA

1998:

**Gruden JF**, Glassman K, Noor M, Sutton P, Seaman C.

“Chest radiographs in cardiovascular surgery patients: recommended versus actual utilization”

Abstract and Presentation. RSNA Scientific Sessions

Chicago, IL

**Gruden JF**, Campagna G, McGuinness G.

“CT appearance of the normal bronchial stump and second carina after left upper lobectomy”

Abstract and Presentation, RSNA Scientific Sessions

Chicago, IL

1997:

**Gruden JF**, Huang L, Swanson MS, Turner J, Merrifield C, Hopewell PC.

“Chest radiograph-based probability classification for possible *Pneumocystis carinii* pneumonia (PCP) in patients with AIDS: prospective evaluation in 392 patients”

Abstract and Presentation, RSNA Scientific Sessions

Chicago, IL

**Gruden JF**, McGuinness G, Webb WR, Naidich DP.

“Nodule localization on HRCT: evaluation of a simple algorithm”

Abstract and Presentation, American Roentgen Ray Society Meeting  
Washington DC

1996:

**Gruden JF**, Harkin T, Addrizzo D, McGuinness G, Bhalla M, Naidich DP.

“Three-dimensional virtual bronchoscopy: correlation with fiberoptic bronchoscopy in normal and diseased airways”

Abstract and Presentation, RSNA Scientific Sessions  
Chicago, IL

1995:

**Gruden JF**, Huang L, Webb WR, Gamsu G, Turner J, Stansell JD, Hopewell PC.

“HRCT in HIV-seropositive patients with respiratory symptoms and normal, equivocal, or nonspecific chest radiographs”

Abstract and Presentation, RSNA Scientific Sessions  
Chicago, IL

**Gruden JF**, Huang L, Webb WR, Gamsu G, Hopewell PC, Sides DM.

“AIDS-related pulmonary KS: radiographic findings and staging system with bronchoscopic correlation in 76 patients”

Abstract and Presentation, American Roentgen Ray Society  
Washington, DC

**Gruden JF**, Murray JF, Webb WR.

“Pitfalls in HRCT interpretation”

Scientific Exhibit, American Roentgen Ray Society  
Washington, DC

Oldham SAA, **Gruden JF**.

AIDS-related neoplasms: can we tell them apart?

Scientific Exhibit, RSNA  
Chicago, IL

**Gruden JF**, Murray JF, Webb WR.

“Pitfalls in HRCT interpretation”

Scientific Exhibit, Roentgen Centenary Congress  
Birmingham UK

1994:

**Gruden JF**, Webb WR, Yao DC, Klein JS, Sandhu JS.

“Bronchogenic carcinoma in patients infected with the human immunodeficiency virus (HIV): clinical and radiographic manifestations”  
Abstract and Presentation, American Roentgen Ray Society Meeting

**Gruden JF**, Webb WR, Warnock M.

“Centrilobular opacities on HRCT: diagnostic considerations and pathologic correlation”  
Abstract and Presentation, American Roentgen Ray Society Meeting

Huang L, Schnapp LM, **Gruden JF**, Hopewell PC, Stansell JD

“Clinical and radiographic presentation of pulmonary Kaposi's sarcoma”  
Exhibit, International Symposium on AIDS  
Yokahama, Japan

1993:

**Gruden JF**, Klein JS, Webb WR.

“Transthoracic needle biopsy in AIDS”

Abstract and Presentation, Society of Thoracic Radiology  
Hilton Head, SC

**Gruden JF**, Klein JS

“The thoracic manifestations of AIDS and HIV disease”  
Exhibit, American Roentgen Ray Society  
San Francisco, CA

# Exhibit B

Below is a list of all cases in which, during the previous 4 years, I have testified as an expert at trial or by deposition.

1. In 2018, I testified as an expert in the matter of *Ingram v. Blanco*; and
2. In 2019, I testified as an expert in the matter of *Bosco v. Staten Island University Hospital*.

# Exhibit 000

1 UNITED STATES DISTRICT COURT

2 DISTRICT OF MASSACHUSETTS

3 -----x

4 CHARU DESAI,

5 Plaintiff,

6 vs.

Civil Action No.  
4:19-cv-10520-DHH

7  
8 UMASS MEMORIAL MEDICAL CENTER,  
INC., ET AL.,

9 Defendants.

10 -----x

11  
12  
13  
14 DEPOSITION OF ELLA KAZEROONI, M.D., M.S.

15 Conducted Remotely

16 1500 East Medical Center Drive

17 Ann Arbor, Michigan

18 October 21, 2021

19 8:34 a.m. to 2:51 p.m.

20  
21  
22  
23  
24 Reporter: Laurie J. Berg, CCR, RPR, CRR, CLR, CER

1 Q. You have -- you have no opinion -- or you  
2 have offered no opinion as to whether the criticisms  
3 that Dr. Litmanovich raise warranted Dr. Desai's  
4 termination; is that correct?

5 A. I have no opinion.

6 Q. I'm sorry, could you repeat that?

7 A. I have no opinion on that question.

8 Q. I believe that we left off on QACH33; is that  
9 correct?

10 MS. WASHIENKO: Reid, is that what you  
11 have?

12 MR. WAKEFIELD: It -- I thought we got  
13 to 34, but I could be mistaken. I thought we were --  
14 we got to 34. Maybe we were at 38, but that's my  
15 recollection.

16 A. (Deponent viewing exhibit.) Yeah, my  
17 recollection is we got through -- unless you have  
18 anything more on 34, and 38 was the next break point.

19 Q. All right. well, I'll just pick up on 34,  
20 then, really quickly.

21 with regard to the -- your identification of  
22 the -- of reticulonodule infiltrate as not being in  
23 use anymore, and I -- I think that's a -- a fair  
24 characterization of what you said; is that the kind of

# Exhibit PPP

# Chest CT QA study CONFIDENTIAL

January 26, 2017

## Methods

- 50 random Chest CTs
  - 25 CD
  - 25 Control (several radiologists)
- Blinded review, experienced chest Radiologist not at UMMMC
  - Discrepancy Y/N
    - Detail of discrepancy
  - Major / Minor
  - Impact on patient care Y/N

# Discrepancies

- CD

- 10/25 (40%)
  - Major 5/25 (20%)
  - Minor 5/25 (20%)

- Control group

- 8/25 (32%)
  - Major 1/25 (4%)
  - Minor 7/25 (28%)

Count of RAD	Column Labels			
Row Labels	Major	Minor	(blank)	Grand Total
CD	5	5	15	25
O	1	7	17	25
(blank)				
Grand Total	6	12	32	50

## Major Discrepancies, Impact on patient care

- CTA (008)
  - No distinction made in the report between pneumonia and rounded atelectasis, all named consolidations, where , in fact, right lower lobe and lingular rounded atelectasis are less important than large pneumonia in left lower lobe in the post-operative lung
- CTA (009)
  - No pulmonary edema seen, the findings are of multifocal infection or less likely fat emboli, to be considered under those clinical circumstances
- CTPA (010)
  - Multifocal pneumonia and bronchitis not clearly stated

## Major (cont.)

- I- CT (030)
  - Extensive secretions in trachea,
  - Most likely aspiration in left lung base AND potentially pneumonia in left apex. No mentioning if new or old or no comparison available
  - Mediastinal Lymph nodes are most likely reactive
- I- (033)
  - Lower right chest tube is not in the pleural space, this is not clearly stated
- Control group I- (022)
  - Severe bronchiectasis and air trapping,
  - Findings concerning for MAI, not even mentioned

## Impact on patient care

Count of RAD	Column Labels				
Row Labels	No	No?	Yes	(blank)	Grand Total
CD		1	9	15	25
O		1	5	19	25
Grand Total		1	14	34	50

- CD:
  - Yes 9/25 (36%)
  - No? 1/25 (4%)
- Control:
  - Yes 5/25 (20%)
  - No 1/25 (4%)

# Summary

	CD	Control
Any Discrepancy	10/25 (40%)	8/25 (32%)
Major Discrepancy	5/25 (20%)	1/25 (4%)
Impact on patient care	9/25 (36%) plus one ? Impact	5/25 (20%)

# Exhibit QQQ



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August 13, 2019

Darren Brennan, MD  
Department of Radiology  
UMass Memorial Medical Center  
55 Lake Avenue North  
Worcester, MA 01655

Max P. Rosen, MD, MPH, FACR  
Professor and Chair

Dear Darren,

I am writing to finalize our discussion about your role and time commitment to the department effective September 1, 2019.

At your request, starting September 1, 2019, you will be stepping down from the Vice Chair for Enterprise Operations and Community Radiology role and will be reducing your commitment from 0.6 FTE to 0.525 FTE at a base salary of \$178,500 ( $\$340,000 \times 0.525$ ).

You will work 97 clinical weekdays and will be allocated 26 administrative days. As a 0.525 FTE, you will be responsible for 10.5 weekend days and your pro-rated share of holidays. If you work above and beyond the above prorated number of calls, you will be compensated at the current weekend moonlighting rate of \$1,600.

Your practice allowance will be prorated at 52.5% (\$2,088). We will pay for your malpractice and will provide full radiology physician benefits and pro-rated vacation and holiday time (19 vacation days and 5 holidays) per UMASS Memorial Medical Group Physician Benefits At-A-Glance 2019 (attached).

Best,

Max P. Rosen, MD, MPH  
Professor & Chair  
Department of Radiology

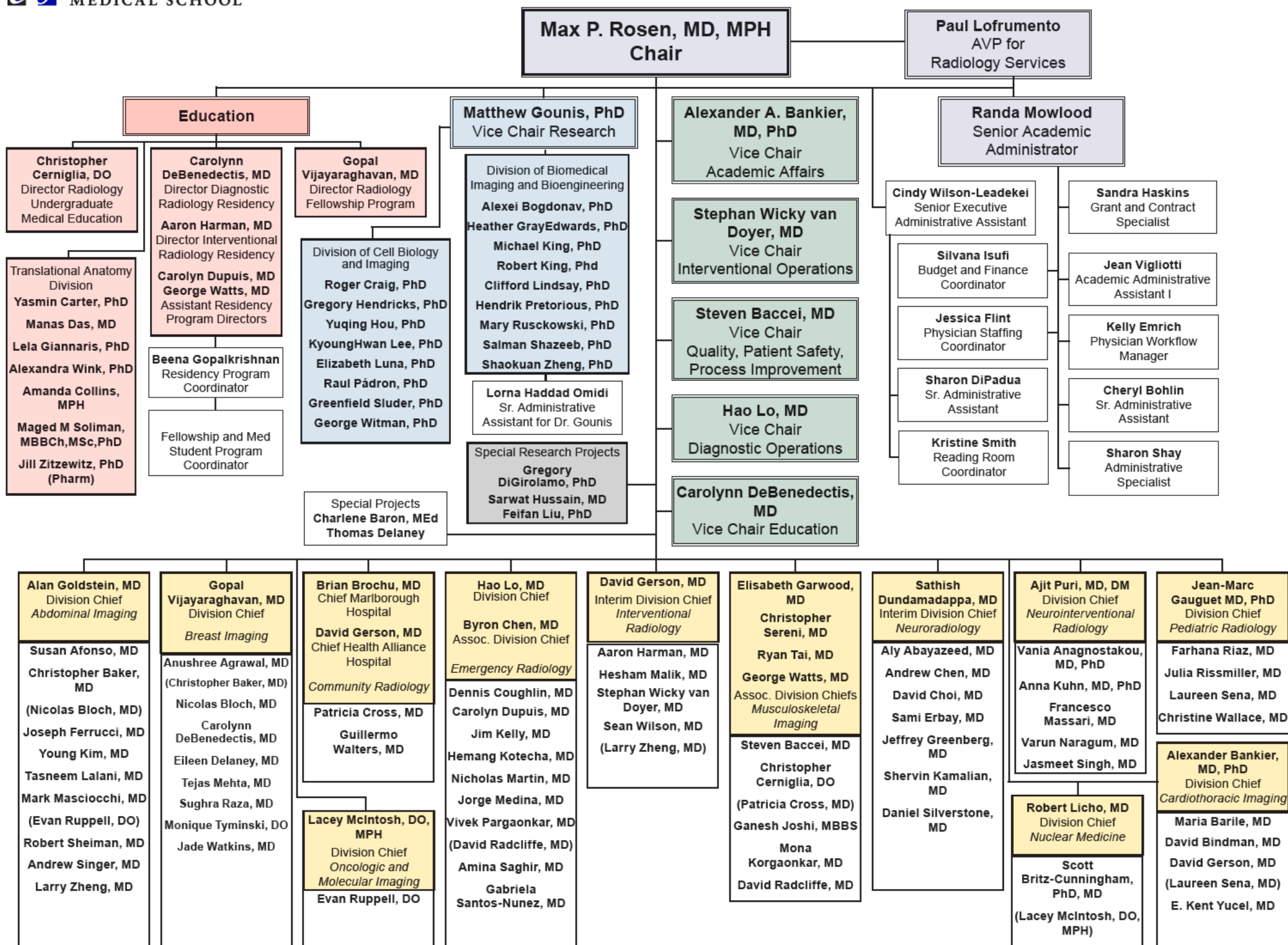
Acknowledged and Agreed:

  
Darren Brennan, MD

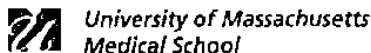
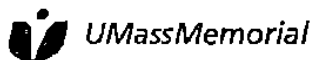
8/13/2019.  
Date:

# Exhibit RRR

# UMass Radiology Organizational Chart



# Exhibit SSS



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Max P. Rosen, MD, MPH, FACP  
Professor and Chair

VIA HAND DELIVERY

March 9, 2018

Charu Desai, MD  
Department of Radiology  
UMass Memorial Medical Group  
55 Lake Avenue North  
Worcester, MA 01655

RE: *Notice of Termination of Employment*

Dear Dr. Desai:

As Dr. Rosen has discussed with you, this letter serves as notice that your employment with UMass Memorial Medical Group and the University of Massachusetts Medical School will terminate on March 17, 2019.

Kathleen LeBlanc in our Human Resources Department will be available to discuss any questions you may have regarding benefits and related matters.

Thank you for your efforts and contributions on behalf of the Medical Group and the Medical School.

Sincerely,

Max Rosen, MD  
Chair, Department of Radiology

Stephen Tosi, MD, President  
UMass Memorial Medical Group

Cc: LuAnn Thorndyke, MD

UMM 00253

# Exhibit TTT



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Medical School

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Max P. Rosen, MD, MPH, FACR  
Professor and Chair

**VIA HAND DELIVERY**

April 10, 2014

Herlen Alencar, MD  
UMass Memorial Medical Group  
Department of Radiology  
55 Lake Avenue North  
Worcester, MA 01655

RE: Offer of One Year Extension of Employment

Dear Herlen:

As we have discussed, I am writing to confirm our understanding with regard to our offer to extend your employment beyond the termination date of July 18, 2014. This letter will serve to document our understanding regarding the terms and conditions of this offer.

Your current employment agreement will expire on July 18, 2014. As of that date, per this letter, your employment will be extended for a period of one (1) year, terminating on July 19, 2015. My expectation is that in your new role as a member of the VIR section (rather than as section chief), you will work as a productive member of the clinical team, and will integrate collaboratively with other faculty, technicians, nurses, mid-level providers, and administrators. Collaboration, civility and collegiality are critical components of this expectation. I fully anticipate that you will continue to provide your skilled level of patient care.

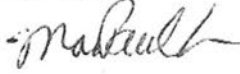
While we will meet informally over the course of the next several months, I will arrange for a formal evaluation of your performance to take place at the end of December, 2014. I will work with Human Resources to determine a number of performance metrics against which your performance may be objectively reviewed. If your performance is less than satisfactory, I will give you six months' notice to confirm that your employment will terminate on July 18, 2015. If things are working out positively at that time, and continue to be satisfactory for the remainder of the one-year term, I would then be willing to propose extending your employment under the traditional UMass Memorial Medical Group contractual model.

Notwithstanding the above, the Medical Group reserves the right to terminate your employment, for cause, if warranted.

As of the July 18, 2014 commencement of this Agreement, your salary will be Five Thousand Eight Hundred Forty Six Dollars and Ninety-Two Cents (\$5,846.92) per week (\$305,040 if annualized) for a full-time position. You would continue to be eligible for the standard UMass Memorial physician benefits package.

If the terms and conditions of this letter meet with your approval, please confirm by signing below and returning a signed copy of this letter to my attention by no later than Friday, April 18, 2014. I look forward to a productive and positive collaboration with you.

Sincerely,



Max Rosen, MD  
Chair, Department of Radiology

Cc: Stephen Tosi, MD  
Michele Streeter  
Kathleen LeBlanc  
Sharon Sambito

Accepted and Agreed:

---

Herlen Alencar, MD  
Date:

# Exhibit UUU

**From:** Desai, Charu <charu.desai@exchange.com>  
**Sent:** Thursday, March 14, 2019 1:50 PM  
**To:** Ddesai1@northwell.edu  
**Subject:** FW: Meeting to Review QA data

---

---

From: Rosen, Max  
Sent: Wednesday, April 18, 2018 5:12 PM  
To: Desai, Charu  
Cc: Rosen, Max  
Subject: Meeting to Review QA data

Dear Dr. Desai,

I will be glad to meet with you, but will not permit an independent reviewer to attend our meeting.

You are welcome to bring a colleague from our Department with you if you wish.

Please call Cindy to schedule a mutually-convenient time for our meeting.

Max

From: Desai, Charu  
Sent: Wednesday, April 18, 2018 2:05 PM  
To: Rosen, Max <Max.Rosen@umassmemorial.org>  
Subject: RE: March 14th, 2018 Meeting

Dr. Rosen,

I accept the offer to meet with you to discuss the assertions you made regarding the quality of my work, both in our meeting on March 14, 2018 and in your email below.

I also accept your offer to have a colleague accompany me. I am concerned, however, that anyone who works under you in the Radiology Department will be placed in an uncomfortable position, and may be reticent to voice their true opinion out of fear of retaliation. Therefore, I would like to choose an independent, expert reviewer to accompany me to this meeting, to ensure neutrality and avoid any potential bias favoring either of our positions on the information presented.

I look forward to speaking with you and hope to arrange a mutually convenient meeting date and time.

Dr. Desai

---

From: Rosen, Max  
Sent: Tuesday, April 17, 2018 3:57 PM  
To: Desai, Charu  
Cc: Tosi, Stephen; Cavagnaro, Charles; Rosen, Max  
Subject: RE: March 14th, 2018 Meeting  
Dear Dr. Desai,

I am writing in response to your email below.

**UMM-03957**

I am happy to set up a meeting for you, myself, and Dr. Baccei – our director for Radiology QA to review the results of the independent analysis that I had performed. As you have asked previously and I am happy to support, you are welcome to invite a colleague to attend this meeting with you.

You will be able to review that data that was presented to me, but will not be able to take any hard-copies of the reports.

Please contact Cindy to schedule if you still want to meet.

Sincerely,

Max

From: Desai, Charu

Sent: Saturday, March 24, 2018 8:29 AM

To: Rosen, Max <Max.Rosen@umassmemorial.org<mailto:Max.Rosen@umassmemorial.org>>

Cc: Tosi, Stephen <Stephen.Tosi@umassmemorial.org<mailto:Stephen.Tosi@umassmemorial.org>>;

Cavagnaro, Charles

<Charles.Cavagnaro@umassmemorial.org<mailto:Charles.Cavagnaro@umassmemorial.org>>

Subject: Re: March 14th, 2018 Meeting

Dear Dr. Rosen,

I am writing regarding the meeting held on March 14, 2018 at noon. In this meeting, you provided me a written letter indicating that my employment at UMMHC would be terminated. You verbalized that this was due to my poor quality work. Can you please elaborate with evidence to substantiate your allegations?

Dr. Desai

# Exhibit VVV

Dr. Arin Zimmerman, MD 4/24/2018

no hand  
copy

① Reviews end of 2016 & 1<sup>st</sup> Quarter of 2017

Summary CD. Control.

Any discrepancy. 10/25 (40%) 8/25 (32%)

Major discrepancy. 5/25 (20%) 1/25 (4%)

Impact on the pt. 9/25 (36%) 5/25 (20%)

Plus one impact.

② Did not tell which hospital.

③ March meeting he stated termination was no cause.

Also stated that have not taken away any privileges.

Did not need to report to board of registration or new job. Just non renewal of contract.

④ will not allow our independent reviewer.

⑤ He fills out forms for everybody every 9 mths.

# Exhibit WWW

**From:** Desai, Charu <charu.desai@exchange.com>  
**Sent:** Thursday, March 14, 2019 1:52 PM  
**To:** Ddesai1@northwell.edu  
**Subject:** FW: Summary of April 24th Meeting Regarding QA Data

---

---

From: Desai, Charu  
Sent: Saturday, April 28, 2018 1:09 PM  
To: Rosen, Max  
Subject: Summary of April 24th Meeting Regarding QA Data

Dr. Rosen,

Thank you for meeting with me earlier this week. I would like to summarize the content of the meeting that took place on April 24th, 2018, at which you, I, Dr. Baccei, and Dr. Hussain were present.

I asked you when the independent review regarding my work quality was performed, at which point you indicated to me that you began the investigation in late 2016 and concluded it in early 2017.

When I requested the name of the independent reviewer and the hospital at which they worked, I was denied that information. When I further asked you for a written copy of the information that you presented to me regarding my alleged deficiencies of quality in my CT scan readings, you denied me the opportunity to document the examples of the "poor quality reports" and the associated patients. Rather you projected them on a screen, which included the reports of several other radiologists, in a manner that was seemingly intentionally disorganized and extremely difficult to comprehend. Furthermore, you provided me a summary report that did not include any concrete examples of my deficiencies, but merely "statistics" from the investigation.

In addition, when I asked to be able to bring another independent reviewer to this meeting, my request was denied.

Lastly, you indicated to me that my termination was for no cause. You then stated that you have terminated others with significantly shorter notice than you gave me (even though I am well aware that my contract states that you are obligated to give me one year notice prior to terminating me shall the circumstance arise). You stated that I could easily get a job elsewhere if I desired, and that your recent actions should not hinder my doing so.

Thank you for your time.

Dr. Desai

# Exhibit XXX

4046177

## UMass Memorial Health Care

Diagnostic Imaging

QACH11

DOB: 9/7/1958

Sex: F

Ordering MD: --

Attending MD: --

Admitting MD:

Study Date	Accession #	Procedure Code	Location	Procedure
3/7/2017	15658659	CTPE1/OCT	A243 A	CT CHEST - PE

## Reason for Study

ME-Respiratory Distress - PE Protocol

## \*\*\* Final Report \*\*\*

## EXAMINATION:

CT Chest with IV Contrast to evaluate for PE.

## INDICATION:

Chest pain. Shortness of breath.

## TECHNIQUE:

CT Chest with IV Contrast to evaluate for PE

Coronal and sagittal reformatted images were also done .

## COMPARISON:

8/2/2015

## FINDINGS:

Slightly limited due to rotation to the right.

## LUNGS:

Lung images are limited due to breathing artifacts. Bilateral lower lobe consolidation, left greater than right question aspiration. Small focal areas of consolidation in the right upper lobe.

Plate atelectasis in the lingula and left upper lobe.

Minimal generalized groundglass opacity probably secondary to vascular congestion.

Very small bilateral pleural effusion.

## MEDIASTINAL WINDOW:

No evidence of pulmonary embolus.

Right PICC line in place.

No mediastinal adenopathy. Mediastinal lipomatosis. No pericardial effusion.

No axillary lymphadenopathy.

4046177

**UMass Memorial Health Care**

Diagnostic Imaging

QACH11

DOB: 9/7/1958

Sex: F

Ordering MD:

Attending MD:

Admitting MD:

**\*\*\* Final Report \*\*\***

**BONY THORAX:**

Degenerative changes are seen in the thoracic spine. Artifacts from metallic hardware at the thoracolumbar junction. Again seen moderate compression fractures of 6,7,8 and T9 vertebra. On current study compression fracture of T4 vertebra not seen on 2015, question age.

Bilateral multiple healing/healed rib fractures .

**IMPRESSION:**

1. No evidence of pulmonary embolus.
2. Bilateral pneumonia as described above. Question aspiration.
3. Other findings as described above.

**COMMUNICATION:**

Per this written report.

Dictated on: 3/7/2017 11:22:48AM

Interpreted by: [REDACTED]

Transcribed by: PowerScribe

Signed by: [REDACTED]

3/7/2017 11:22:48AM

3/7/2017 11:45:56AM

4046177

**UMass Memorial Health Care**

Diagnostic Imaging

QACH 11

DOB: 9/7/1958

Sex: F

Ordering MD:

Attending MD:

Admitting MD:

**\*\*\* Final Report \*\*\***

**BONY THORAX:**

Degenerative changes are seen in the thoracic spine. Artifacts from metallic hardware at the thoracolumbar junction. Again seen moderate compression fractures of 6,7,8 and T9 vertebra. On current study compression fracture of T4 vertebra not seen on 2015, question age.

Bilateral multiple healing/healed rib fractures .

**IMPRESSION:**

1. No evidence of pulmonary embolus.
2. Bilateral pneumonia as described above. Question aspiration.
3. Other findings as described above.

**COMMUNICATION:**

Per this written report.

Dictated on: 3/7/2017 11:22:48AM

Interpreted by: [REDACTED]

Transcribed by: PowerScribe

Signed by: [REDACTED]

3/7/2017 11:22:48AM

3/7/2017 11:45:56AM

4021085

## UMass Memorial Health Care

Diagnostic Imaging

QACH12

DOB: 10/16/1964

Sex: F

Ordering MD:

Attending MD:

Admitting MD:

<u>Study Date</u>	<u>Accession #</u>	<u>Procedure Code</u>	<u>Location</u>	<u>Procedure</u>
2/13/2017	15618194	CTC1/OCT	E-D	CT Chest with contrast
<u>Reason for Study</u>				
UN-trauma- mva- pain				
2/13/2017	15618195	CTAP1/OCT	E-D	CT Abdomen and Pelvis with contrast
<u>Reason for Study</u>				
UN-trauma- mva- pain				
2/13/2017	15618196	CTRETS/OCT	E-D	CT RECONSTRUCTION THORACIC SPINE
<u>Reason for Study</u>				
UN-trauma- mva- pain				
2/13/2017	15618197	CTRELS/OCT	E-D	CT RECONSTRUCTION LUMBAR SPINE
<u>Reason for Study</u>				
UN-trauma- mva- pain				

## \*\*\* Final Report \*\*\*

## COMPARISON:

None

## FINDINGS:

There are nodular groundglass opacities scattered throughout both lungs, most pronounced at the bases. Evaluation of the mediastinum demonstrates no traumatic injury, focal mass lesion or pericardial effusion. The aorta and its major mediastinal branch vessels are normal in course and caliber without traumatic injury.

The liver demonstrates uniform enhancement without intrahepatic ductal dilatation or focal mass lesion. The gallbladder is physiologically distended without gallstones. The hepatic arterial and portal venous flow is widely patent.

The kidneys demonstrate bilateral uniform uptake and excretion of contrast material without hydronephrosis. The pancreas, adrenals and spleen are grossly unremarkable. The patient is status post gastrojejunostomy. The bowel otherwise demonstrates normal course and configuration without obstruction.

The height and alignment of the thoracic and lumbar vertebral bodies is maintained. The disc space heights are preserved.

## IMPRESSION:

1. There are nodular groundglass opacities scattered throughout both lungs, most pronounced at the bases. While findings could represent contusions, the distribution favors a multifocal infectious or inflammatory process.

2. No evidence of acute traumatic injury to the thoracic or lumbar spine.

4021085

**UMass Memorial Health Care**

Diagnostic Imaging

QACH 12

DOB: 10/16/1964

Sex: F

Ordering MD: \_\_\_\_\_

Attending MD: \_\_\_\_\_

Admitting MD: \_\_\_\_\_

**\*\*\* Final Report \*\*\***

3. No acute intraperitoneal traumatic injury.

Dictated on: 2/13/2017 4:56:21PM

Interpreted by: \_\_\_\_\_

Transcribed by: PowerScribe

Signed by: \_\_\_\_\_

2/13/2017 4:56:21PM

2/13/2017 5:01:43PM

4044538

**UMass Memorial Health Care**

Diagnostic Imaging

QACH 25

DOB: 12/20/1956

Sex: M

Ordering MD

Attending MD:

Admitting MD:

<u>Study Date</u>	<u>Accession #</u>	<u>Procedure Code</u>	<u>Location</u>	<u>Procedure</u>
3/6/2017	15598967	CTC0/LD		CT: Chest without Contrast

Reason for Study

MM-CT Chest(0) - Lung Nodule R91.1 71250

**\*\*\* Final Report \*\*\*****EXAMINATION:**

Chest CT without contrast.

**INDICATION:**

Followup lung nodules

**TECHNIQUE:**

Chest CT without contrast

Coronal and sagittal reformatted sequences were provided.

**COMPARISON:**

CT dated 3/2/2016

**FINDINGS:****LUNGS AND PLEURA:**

Patent central airways.

The airways are patent. The lung parenchyma appears grossly unremarkable. Small amount of atelectasis in the left lower lobe and right middle lobe is identified. The study is compared to the previous examination. Again several scattered tiny lung nodules are identified, not significantly changed from before.

Following nodules are identified on series 4 and measure less than 4 mm

Right upper lobe; 217, 242 right middle lobe

Right lower lobe; to a 6, to 65

Left upper lobe;

Left lower lobe; 274

**LYMPH NODES:**

No significant nodes

**MEDIASTINUM:**

Normal sized heart without pericardial effusion. Severe coronary artery calcifications.

Normal diameter thoracic aorta with minimal atherosclerotic calcifications. The aortic root measures about 4 cm.

Normal sized pulmonary arteries.

4003113

## UMass Memorial Health Care

Diagnostic Imaging

QACH 46

DOB: 7/1/1931

Sex: F

Ordering MD:

Attending MD:

Admitting MD:

Study Date	Accession #	Procedure Code	Location	Procedure
1/29/2017	15588807	CTPE1/OCT	M212 B	CT CHEST - PE

Reason for Study

MM-SOB, evaluate for PE

## \*\*\* Final Report \*\*\*

## EXAMINATION:

CT Chest with Contrast to evaluate for PE

## INDICATION:

Chest pain. Shortness of breath.

## TECHNIQUE:

Contrast enhanced CT was performed following administration of Omnipaque 350 intravenous contrast with CT PE protocol. Axial reconstructions at 1, 1.25 or 1.5mm and 5 mm were performed. Coronal and sagittal reformatted sequences were performed. Axial MIP images were performed.

## COMPARISON:

Chest x-ray 1/26/2017, CT PE study 9/1/2016 and previous

## FINDINGS:

**PULMONARY ARTERIES:** This examination is diagnostic to the subsegmental level. There are multiple bilateral pulmonary emboli the and the in are seen CTs and no to in in no with the a right is the

**LUNGS AND PLEURA:** Diffuse mosaic attenuation, more accentuated than on prior. Respiratory motion artifact obscures fine detail of the lower lobes. Subsegmental atelectasis right lower lobe is noted. No pleural effusion or evidence of pulmonary infarct at this time.

## MEDIASTINUM:

There is interval dilatation of the right ventricle when compared to prior CT. For example, the maximal transverse dimension is 4.2 cm, as compared to 3.2 cm on the previous exam. The left ventricle currently measures 3.4 cm. This is indicative of acute right heart strain. No pericardial effusion. No significant coronary arterial calcification.

The appendage is free of thrombus.

Diffuse thickening of the esophagus is again noted with a small hiatal hernia. This is correlated to a barium swallow performed 9/19/2016). No mediastinal or hilar lymphadenopathy.

## Chest wall

No axillary, supraclavicular or subpectoral lymphadenopathy.

4003113

**UMass Memorial Health Care**

Diagnostic Imaging

DOB: 7/1/1931

Sex: F

Ordering MD: ^

Attending MD: - - -

Admitting MD:

---

**\*\*\* Final Report \*\*\***

UPPER ABDOMEN (limited):  
Unremarkable

**BONES:**

No osseous lesions. Thoracic spine degenerative changes. Interval compression fractures of T7 and T8 since September 2016 with exaggerated kyphotic posture. No retropulsed osseous fragments into the canal.

**IMPRESSION:**

1. Multiple bilateral pulmonary emboli, initiate the lobar level in the right and the segmental level on the left. There is interval dilatation of the right ventricle when compared to September 2016, indicative of right heart strain.
2. New compression fractures of T7 and T8.

**COMMUNICATION:**

Per this written report. This was reported via red alert electronic system spoken with Dr Adaramola at 1215 p.m.

Dictated on: 1/29/2017 12:19:41PM

Interpreted by: [REDACTED]

Transcribed by: PowerScribe

Signed by: [REDACTED]

1/29/2017 12:19:41PM

4003113

**UMass Memorial Health Care**

Diagnostic Imaging

DOB: 7/1/1931

Sex: F

Ordering MD: ^

Attending MD: - -

Admitting MD:

---

**\*\*\* Final Report \*\*\***

UPPER ABDOMEN (limited):

Unremarkable

**BONES:**

No osseous lesions. Thoracic spine degenerative changes. interval compression fractures of T7 and T8 since September 2016 with exaggerated kyphotic posture. No retropulsed osseous fragments into the canal.

**IMPRESSION:**

1. Multiple bilateral pulmonary emboli, initiate the lobar level in the right and the segmental level on the left. There is interval dilatation of the right ventricle when compared to September 2016, indicative of right heart strain.

2. New compression fractures of T7 and T8.

**COMMUNICATION:**

Per this written report. This was reported via red alert electronic system spoken with Dr Adaramola at 1215 p.m.

Dictated on: 1/29/2017 12:19:41PM

Interpreted by: [REDACTED]

Transcribed by: PowerScribe

Signed by: [REDACTED]

1/29/2017 12:19:41PM

4027548

## UMass Memorial Health Care

Diagnostic Imaging

QACH20

DOB: 3/20/1969

Sex: F

Ordering MF:

Attending MC

Admitting MD:

Study Date	Accession #	Procedure Code	Location	Procedure
2/18/2017	15628188	CTC0/OCT	U316 A	CT Chest without contrast

Reason for Study

UN-WITH BOTH INSPIRATORY AND EXPIRATORY VIEWS: CHRONIC SOB, EVAL FOR ?TRACHEOBRONCHOMALACIA

## \*\*\* Final Report \*\*\*

EXAMINATION: [CT Chest with contrast]

INDICATION: Chronic shortness of breath

COMPARISON: 2011

## FINDINGS:

## LUNGS :

Parenchyma: And MRI head on the eighth limited MRI head on the eighth the lumbar spine without low with enhancing the multiple myeloma dictated multiple myeloma

Nodules/masses: [ there are no volume forming lung nodules. ]

Airways: To reside clear. No evidence of tracheobronchial calcinosis.

PLEURA: no effusions

LYMPH NODES: No enlarged hilar or mediastinal lymph nodes.

## MEDIASTINUM:

Heart: [Normal sized heart without pericardial effusion]. Mild coronary coronary artery calcifications.

Aorta: [Normal diameter thoracic aorta] , mild atherosclerotic calcifications.

Pulmonary: Normal sized pulmonary arteries.

LOWER NECK/THORACIC INLET : Unremarkable

UPPER ABDOMEN: (limited): There are surgical suture line at the GE junction. Probably partial gastrectomy. Gallbladder has been removed.

BONES: No osseous lesions. Thoracic spine age appropriate changes. Preservation of vertebral body heights.

## IMPRESSION:

1. Normal lungs airways. No tracheobronchial calcinosis found.
2. Lungs are clear.
3. No CT evidence of significant interstitial lung disease.

4027548

**UMass Memorial Health Care**

Diagnostic Imaging

QACH 20

DOB: 3/20/1969

Sex: F

Ordering MD: ' - " -

Attending MD:

Admitting MD:

**\*\*\* Final Report \*\*\***

COMMUNICATION: Per this written report.

Dictated on: 2/18/2017 4:22:30PM

Interpreted by: [REDACTED]

Transcribed by: PowerScribe

Signed by: [REDACTED]

2/18/2017 4:22:30PM

2/18/2017 4:32:47PM

4027548

**UMass Memorial Health Care**

Diagnostic Imaging

QACH 20

DOB: 3/20/1969

Sex: F

Ordering MD: [REDACTED]

Attending MD:

Admitting MD:

**\*\*\* Final Report \*\*\***

COMMUNICATION: Per this written report.

Dictated on: 2/18/2017 4:22:30PM

Interpreted by: [REDACTED]

Transcribed by: PowerScribe

Signed by: [REDACTED]

2/18/2017 4:22:30PM

2/18/2017 4:32:47PM

# Exhibit YY

**From:** Unspecified Sender  
**Sent:**  
**To:** Rosen, Max <Max.Rosen@umassmemorial.org>  
**Subject:** RE: Confidential - Cardiothoracic Radiology staffing

---

OMG. Well you said that the

---

**From:** Rosen, Max  
**Sent:** Tuesday, October 03, 2017 9:34 PM  
**To:** Tosi, Stephen <Stephen.Tosi@umassmemorial.org>; Streeter, Michele <Michele.Streeter@umassmemorial.org>  
**Cc:** Mowlood, Randa <Randa.Mowlood@umassmemorial.org>  
**Subject:** RE: Confidential - Cardiothoracic Radiology staffing

Thanks Steve.

Juts spoke with Candidate.

Not sure he will come. He has a starting offer for \$480K at Geisinger , with 7 weeks vacation/CME.

I'll keep you both posted./ Max

**Max P. Rosen MD MPH**  
**Professor and Chairman**  
**Department of Radiology**  
**UMass Memorial Medical Center**  
**55 Lake Avenue North - Room S2-824**  
**Worcester, MA 01655**  
**Phone: 508/856-3252**  
**Fax: 508/856-4910**

[max.rosen@umassmemorial.org](mailto:max.rosen@umassmemorial.org)

---

**From:** Tosi, Stephen  
**Sent:** Tuesday, October 03, 2017 6:18 PM  
**To:** Rosen, Max; Streeter, Michele  
**Cc:** Mowlood, Randa  
**Subject:** RE: Confidential - Cardiothoracic Radiology staffing

Hello everyone,

After reviewing all of these emails and Max's contingency plans for mitigating the three month overlap cost of the Desai payout, and factoring in the concerns about the backlog of chest CTs, I feel that we should approve making the offer to the chest radiologist who is finishing his fellowship at UPenn in 6/18 . So, I am officially approving it.

Thanks

Steve Tosi

*Stephen E. Tosi, MD*  
Senior Vice President/Chief Physician Executive  
Chief Medical Officer, UMMHC  
President, UMass Memorial Medical Group

365 Plantation Street, Suite 300  
Worcester, MA 01605  
phone: 508-334-7746  
fax: 508-334-0333

Administrative Assistant: Wendy Schellhammer  
[Wendy.schellhammer@umassmemorial.org](mailto:Wendy.schellhammer@umassmemorial.org)

**UMM-04998**

508-334-7746/fax 508-334-0333

---

**From:** Rosen, Max  
**Sent:** Tuesday, October 03, 2017 12:35 PM  
**To:** Streeter, Michele <[Michele.Streeter@umassmemorial.org](mailto:Michele.Streeter@umassmemorial.org)>  
**Cc:** Mowlood, Randa <[Randa.Mowlood@umassmemorial.org](mailto:Randa.Mowlood@umassmemorial.org)>; Tosi, Stephen <[Stephen.Tosi@umassmemorial.org](mailto:Stephen.Tosi@umassmemorial.org)>; Rosen, Max <[Max.Rosen@umassmemorial.org](mailto:Max.Rosen@umassmemorial.org)>  
**Subject:** Re: Confidential - Cardiothoracic Radiology staffing

I would find a way to eliminate 3 months of an FTE for Q4 2018. I have flexibility with Mona's year to year contract which expires on June 30 2018. If I had to I would give her the "summer off" and move Dr. Ferrucci to 100% MSK as chest X-rays would be covered.

I can also see when the new hire wants to start.

He might want July off to move and have vacation and start in August.

That combination would pay for the 3 month overlap.

Max

Sent from my iPhone

On Oct 3, 2017, at 12:20 PM, Streeter, Michele <[Michele.Streeter@umassmemorial.org](mailto:Michele.Streeter@umassmemorial.org)> wrote:

The real impact of replacing Desai is the 3 months that you will have both.  
How much \$ is that?  
I am just concerned that we are starting off in a big hole.

**From:** Rosen, Max  
**Sent:** Tuesday, October 03, 2017 12:16 PM  
**To:** Streeter, Michele <[Michele.Streeter@umassmemorial.org](mailto:Michele.Streeter@umassmemorial.org)>  
**Cc:** Mowlood, Randa <[Randa.Mowlood@umassmemorial.org](mailto:Randa.Mowlood@umassmemorial.org)>; Tosi, Stephen <[Stephen.Tosi@umassmemorial.org](mailto:Stephen.Tosi@umassmemorial.org)>; Rosen, Max <[Max.Rosen@umassmemorial.org](mailto:Max.Rosen@umassmemorial.org)>  
**Subject:** Re: Confidential - Cardiothoracic Radiology staffing

Is there any way to expedite this.

I've been looking for a fellowship trained chest radiologist for 3 years and finally found someone who wants to come to umass.

If I don't hire him I'm just going to be backfilling chest with per-diems. On any given day we now have 50-100 unread Chest CTs

If Charu leaves and I don't replace her I will not be able to provide adequate clinical service in chest.

I'm CC'ing Steve as I think he has been aware of our problems providing timely reads of Chest CTs.

Max

**UMM-04999**

Sent from my iPhone

On Oct 3, 2017, at 11:20 AM, Streeter, Michele <[Michele.Streeter@umassmemorial.org](mailto:Michele.Streeter@umassmemorial.org)> wrote:

I don't think so. Because of your variance, this would need to go to visiting committee.

I need to catch up with Paula to see where we are at with that

---

**From:** Rosen, Max

**Sent:** Tuesday, October 03, 2017 11:17 AM

**To:** Streeter, Michele <[Michele.Streeter@umassmemorial.org](mailto:Michele.Streeter@umassmemorial.org)>

**Cc:** Mowlood, Randa <[Randa.Mowlood@umassmemorial.org](mailto:Randa.Mowlood@umassmemorial.org)>; Rosen, Max <[Max.Rosen@umassmemorial.org](mailto:Max.Rosen@umassmemorial.org)>

**Subject:** Confidential - Cardiothoracic Radiology staffing

Hi Michele,

I have found a great chest Radiologist finished a cardiothoracic fellowship at UPenn in June 2018. His in-laws live in central Mass.

I would like to make him an offer, but have not formally resolved Dr. Desai's employment – planned for 9/30/18. I am working with Kathleen and Murial, but want to make sure that this is done in the "best" way possible.

If for some Reason Dr. Desai is still employed after 9/30/18 I would make other staffing adjustments so that the new hires addition to the department would be "staffing neutral".

Can I go ahead and make him the offer?

Thanks. Max

Max P. Rosen, MD MPH  
Professor and Chair  
U Mass Memorial Medical Center  
U Mass School of Medicine  
55 Lake Ave. North - Room S2-824  
Worcester, MA 01655  
508-856-3252  
508-856-4910 fax

[max.rosen@umassmemorial.org](mailto:max.rosen@umassmemorial.org)  
Follow me on [LinkedIn](#) or [Twitter](#)  
[www.umassmed.edu/radiology](http://www.umassmed.edu/radiology)

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**UMM-05000**

*or permanently delete all copies of the original message.*

# Exhibit ZZZ

**From:** Leblanc, Kathleen (Human Resource Med Group) <leblanc,kathleen94d@exchange.com>  
**Sent:** Tuesday, October 3, 2017 4:57 PM  
**To:** Rosen, Max <Max.Rosen@umassmemorial.org>  
**Cc:** Mowlood, Randa <Randa.Mowlood@umassmemorial.org>  
**Subject:** RE: confidential

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Sure! Let me know when you are free

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From: Rosen, Max  
Sent: Tuesday, October 03, 2017 4:56 PM  
To: Leblanc, Kathleen (Human Resource Med Group) <Kathleen.Leblanc2@umassmemorial.org>  
Cc: Mowlood, Randa <Randa.Mowlood@umassmemorial.org>  
Subject: confidential

Dr. Desai,

Hi – do you have time talk more about Dr. Desai. I’ve been thinking a lot about how to do this – and want to run some things past you.

Thanks. Max

Max P. Rosen, MD MPH  
Professor and Chair  
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U Mass School of Medicine  
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Worcester, MA 01655  
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